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# PSY 601

## GENERAL PSYCHIATRY


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**Course code: PSY 601**

**Course title: General Psychiatry**

**Course credit load: 3 Units**

# Series 1: History, Aetiology, Ethics, and Neuroscience of Psychiatric Disorders

- **Part 1.1: History and Definition of Psychiatry**
  - Sub Part 1.1.1: Historical milestones in the development of psychiatry
  - Sub Part 1.1.2: Defining psychiatry as a medical discipline
  - Sub Part 1.1.3: The biopsychosocial model
- **Part 1.2: Aetiological Factors and Hypotheses in Mental Illness**
  - Sub Part 1.2.1: Biological factors in the causation of mental illness
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  - Sub Part 1.2.3: Social and environmental factors in the causation of mental illness
- **Part 1.3: Ethics in Psychiatry**
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- **Part 1.5: Neurophysiology of Integrated Behaviour**
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  - Sub Part 1.5.3: The biological foundation of human behaviour as a unifying framework

## Introduction

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Psychiatry occupies a genuinely distinctive position within medicine, treating conditions whose underlying causes span biological, psychological, and social domains simultaneously, and whose own understanding has shifted dramatically across recorded history. This opening Series of **PSY 601: General Psychiatry** builds the essential foundation for everything that follows, working through the **history and definition of psychiatry** itself, the **aetiological factors and hypotheses** underlying mental illness, the **ethical principles** genuinely distinctive to psychiatric practice, and, finally, the **neuroscience** and **neurophysiology** underpinning the biological basis of human behaviour.

The aim of this Series is to equip you with a thorough understanding of milestones in the historical development of psychiatry, factors and hypotheses in the causation of mental illness, the biological foundation of human behaviour, and the application of principles of medical ethics in psychiatry.

This Series begins with **history and definition of psychiatry**, before turning to **aetiological factors and hypotheses in mental illness**, **ethics in psychiatry**, and **neuroscience of psychiatric disorders**. It concludes with **neurophysiology of integrated behaviour**.

## Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 1.1:** illustrate milestones in the historical development of psychiatry and define psychiatry as a discipline
- **SLO 1.2:** describe the biopsychosocial model
- **SLO 1.3:** list biological, psychological, and social factors and hypotheses in the causation of mental illness
- **SLO 1.4:** describe the principles of medical ethics applied to psychiatry
- **SLO 1.5:** describe confidentiality, capacity, and involuntary treatment in psychiatric practice
- **SLO 1.6:** describe neural networks and neurotransmitters relevant to psychiatric disorders
- **SLO 1.7:** describe brain plasticity and genetics of psychiatric disorders
- **SLO 1.8:** describe the prefrontal cortex and executive functioning
- **SLO 1.9:** describe the neurophysiological basis of integrated behaviour, and
- **SLO 1.10:** explain the biological foundation of human behaviour as a unifying clinical framework.

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# 1.1 History and Definition of Psychiatry

## 1.1.1 historical milestones in the development of psychiatry

### From moral treatment to modern evidence-based practice

Psychiatry's historical development, discussed throughout this Series, includes genuinely important milestones such as the **moral treatment movement**, discussed in relation to nineteenth-century asylum reform, replacing custodial confinement with a more humane, therapeutic model, and the mid-twentieth-century **deinstitutionalisation** movement, shifting care increasingly toward community settings.

Further recognised milestones, discussed earlier in this sub-Part, include the development of formal diagnostic classification systems, discussed further later in this course, and the emergence of effective psychotropic pharmacotherapy from the mid-twentieth century onward, together transforming psychiatry from a genuinely descriptive, largely custodial discipline into a genuinely evidence-based medical specialty.

**Fill in the blank:** Psychiatry's historical development includes the moral treatment movement, replacing custodial confinement with a more humane, therapeutic _____.

## 1.1.2 defining psychiatry as a medical discipline

### A specialty defined by its distinctive scope and method

**Psychiatry** is defined as the medical specialty concerned with the diagnosis, treatment, and prevention of mental, emotional, and behavioural disorders, genuinely distinguished from related disciplines such as clinical psychology by its specific medical training and, consequently, its capacity to prescribe pharmacological treatment.

This definition, discussed earlier in this sub-Part, reflects psychiatry's genuinely integrative nature, drawing simultaneously on neuroscience, pharmacology, psychology, and social science, meaning psychiatric practice demands a genuinely broader, more integrative clinical approach than many other medical specialties addressing more narrowly defined organ systems alone.

**Fill in the blank:** Psychiatry is defined as the medical specialty concerned with the diagnosis, treatment, and prevention of mental, emotional, and behavioural _____.

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## 1.1.3 the biopsychosocial model

### A framework integrating three genuinely distinct causal domains

The **biopsychosocial model**, discussed throughout this Series, provides the genuinely foundational conceptual framework for modern psychiatric practice, recognising that mental illness generally results from the combined interaction of **biological**, **psychological**, and **social** factors rather than any single domain acting in genuine isolation.

This integrative model, discussed earlier in this sub-Part, directly shapes both psychiatric assessment, discussed further in a later Series of this course, and treatment planning, since a genuinely comprehensive psychiatric formulation must consider contributing factors from each of these three domains rather than focusing narrowly on any one alone.

**Fill in the blank:** The biopsychosocial model recognises that mental illness generally results from the combined interaction of biological, psychological, and social factors rather than any single domain acting in genuine _____.

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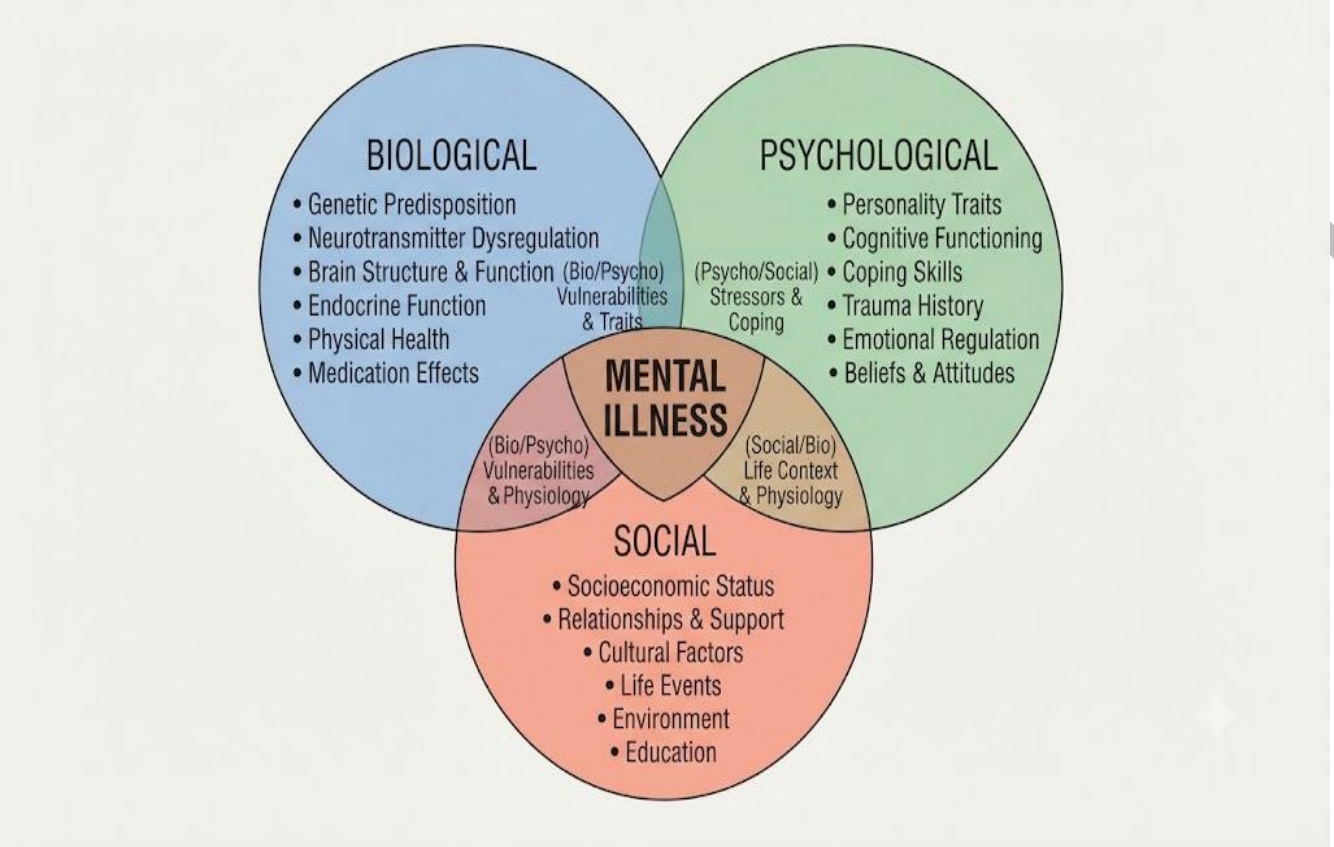


Figure 1.1: A diagram illustrating the biopsychosocial model, showing the interaction of biological, psychological, and social domains in mental illness.

**Pilot questions 1.1**

1. Describe key historical milestones in the development of psychiatry. (Linked to SLO 1.1)
2. Explain the significance of the moral treatment movement. (Linked to SLO 1.1)
3. Define psychiatry as a medical discipline. (Linked to SLO 1.1)
4. Describe the biopsychosocial model. (Linked to SLO 1.2)
5. Explain why the biopsychosocial model directly shapes psychiatric formulation. (Linked to SLO 1.2)

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# 1.2 Aetiological Factors and Hypotheses in Mental Illness

## 1.2.1 biological factors in the causation of mental illness

### Genetic, neurochemical, and structural contributions

**Biological factors**, discussed throughout this Part, include genetic predisposition, discussed further later in this Series, neurotransmitter dysregulation, and structural or functional brain abnormality, together contributing to the recognised biological vulnerability underlying many psychiatric disorders discussed throughout this course.

This biological contribution, discussed earlier in this sub-Part, does not operate in genuine isolation, since environmental and psychological factors, discussed further in this Part, frequently interact with underlying biological vulnerability, meaning biological causation should genuinely be understood as one important, though rarely sole, contributing factor.

**Fill in the blank:** Biological factors include genetic predisposition, neurotransmitter dysregulation, and structural or functional brain _____.

## 1.2.2 psychological factors in the causation of mental illness

### Cognitive, developmental, and personality-based contributions

**Psychological factors**, discussed throughout this Part, include maladaptive cognitive patterns, discussed in relation to cognitive theory, early developmental experience, and personality vulnerability, each contributing to an individual's genuine, specific psychological susceptibility to developing a particular mental disorder.

These psychological factors, discussed earlier in this sub-Part, generally interact meaningfully with biological vulnerability, discussed earlier in this Series, and with the social factors discussed further in the next sub-Part, meaning psychological causation represents a further genuinely important, though similarly rarely sole, contributing domain.

**Fill in the blank:** Psychological factors include maladaptive cognitive patterns, early developmental experience, and personality _____.

## 1.2.3 social and environmental factors in the causation of mental illness

### Life circumstance and adversity as genuine contributing causes

**Social and environmental factors**, discussed throughout this Part, include socioeconomic adversity, significant life stressors, and social isolation, each recognised as genuine, meaningful

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contributing factors to mental illness causation, particularly in individuals who additionally carry biological or psychological vulnerability discussed earlier in this Series.

Recognising this specific social dimension, discussed earlier in this sub-Part, carries direct clinical relevance, since effective psychiatric management frequently requires addressing these social and environmental contributing factors alongside biological and psychological treatment, reflecting the genuinely integrative, biopsychosocial approach discussed earlier in this Series.

**Fill in the blank:** Social and environmental factors include socioeconomic adversity, significant life stressors, and social _____.

**Table 1.2: The three domains of the biopsychosocial model.**

| Domain | Example factor | Clinical relevance |
|---|---|---|
| Biological | Genetic predisposition, neurotransmitter dysregulation | Informs pharmacological treatment planning |
| Psychological | Maladaptive cognition, developmental experience | Informs psychotherapeutic treatment planning |
| Social | Socioeconomic adversity, life stressors | Informs social intervention and support planning |

**Pilot questions 1.2**

1. List biological factors in the causation of mental illness. (Linked to SLO 1.3)
2. Explain why biological causation is rarely a sole contributing factor. (Linked to SLO 1.3)
3. List psychological factors in the causation of mental illness. (Linked to SLO 1.3)
4. List social and environmental factors in the causation of mental illness. (Linked to SLO 1.3)
5. Explain the clinical relevance of recognising the social dimension of mental illness causation. (Linked to SLO 1.3)

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# 1.3 Ethics in Psychiatry

## 1.3.1 principles of medical ethics applied to psychiatry

### Standard bioethical principles carrying particular psychiatric weight

The standard bioethical principles, **autonomy**, **beneficence**, **non-maleficence**, and **justice**, discussed throughout this Part, apply to psychiatric practice with particular weight, since psychiatric disorders can themselves genuinely affect a patient's own capacity for autonomous decision-making, discussed further in the next sub-Part, complicating straightforward application of these otherwise standard principles.

This genuine complexity, discussed earlier in this sub-Part, means psychiatric ethics demands particularly careful, individualised judgement regarding how these standard principles should be applied in any given specific clinical situation, meaning ethical reasoning represents a genuinely essential, ongoing component of everyday psychiatric practice rather than an occasional, exceptional consideration.

**Fill in the blank:** The standard bioethical principles apply to psychiatric practice with particular weight, since psychiatric disorders can themselves genuinely affect a patient's own capacity for autonomous _____.

## 1.3.2 confidentiality and capacity in psychiatric practice

### Two genuinely central, interrelated ethical considerations

**Confidentiality**, discussed throughout this Part, carries particular significance in psychiatric practice given the genuinely sensitive, personal nature of psychiatric information, while **capacity**, the patient's own ability to understand, retain, and weigh relevant information to reach a genuine decision, must be carefully, specifically assessed rather than simply assumed.

These two considerations, discussed earlier in this sub-Part, frequently interact in practice, since a patient found to genuinely lack decision-making capacity may require specific disclosure to family members or other involved parties that would otherwise breach standard confidentiality, meaning genuinely careful, individualised ethical judgement remains essential.

**Fill in the blank:** Capacity is the patient's own ability to understand, retain, and weigh relevant information to reach a genuine decision, and must be carefully, specifically assessed rather than simply _____.

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### 1.3.3 involuntary treatment and ethical safeguards

#### Balancing autonomy against genuine risk of harm

**Involuntary treatment**, discussed in relation to capacity assessment earlier in this Part, may genuinely become necessary where a patient's mental disorder creates significant risk of harm to themselves or others and they lack the capacity to consent to needed treatment, representing a genuine, careful exception to the standard principle of patient autonomy.

This exception, discussed earlier in this sub-Part, is generally surrounded by specific legal and ethical safeguards, including formal capacity assessment, independent review, and the principle of using the genuinely least restrictive intervention necessary, meaning involuntary treatment should always represent a carefully justified, safeguarded exception rather than a routine clinical option.

**Fill in the blank:** Involuntary treatment is generally surrounded by specific legal and ethical safeguards, including formal capacity assessment, independent review, and the principle of using the genuinely least restrictive intervention _____.

Pilot questions 1.3

1. List the standard bioethical principles applied to psychiatry. (Linked to SLO 1.4)
2. Explain why psychiatric disorders complicate application of standard bioethical principles. (Linked to SLO 1.4)
3. Define capacity. (Linked to SLO 1.5)
4. Explain how confidentiality and capacity assessment can interact in practice. (Linked to SLO 1.5)
5. Describe the ethical safeguards surrounding involuntary treatment. (Linked to SLO 1.5)

## 1.4 Neuroscience of Psychiatric Disorders

### 1.4.1 neural networks and neurotransmitters

#### Chemical messengers underlying mood, cognition, and behaviour

**Neural networks** and their communicating **neurotransmitters**, discussed throughout this Part, provide the essential biological substrate for mood, cognition, and behaviour, with dysregulation of key neurotransmitter systems, including serotonin, dopamine, and noradrenaline, discussed

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further in relation to specific disorders in later Series of this course, implicated across a wide range of psychiatric conditions.

Understanding these specific neurotransmitter systems, discussed earlier in this sub-Part, directly underpins rational psychopharmacological treatment, discussed further in a later Series of this course, since most currently available psychotropic medications act specifically by modulating these same neurotransmitter systems in a genuinely targeted, mechanistically informed way.

**Fill in the blank:** Neural networks and their communicating neurotransmitters provide the essential biological substrate for mood, cognition, and _____.

## 1.4.2 brain plasticity and genetics of psychiatric disorders

### A dynamic, genetically influenced biological substrate

**Brain plasticity**, discussed throughout this Part, the brain's genuine capacity for structural and functional reorganisation in response to experience, means the neurobiological substrate of mental illness is not genuinely fixed, offering both a mechanism through which psychiatric illness develops and a genuine therapeutic target for both pharmacological and psychotherapeutic intervention.

**Genetics**, discussed earlier in this sub-Part, contributes meaningfully to psychiatric illness risk across essentially every major diagnostic category, though generally through a complex, polygenic pattern of inheritance rather than any single, deterministic genetic cause, meaning genetic risk should genuinely be understood as probabilistic vulnerability rather than certain predetermination.

**Fill in the blank:** Genetics contributes meaningfully to psychiatric illness risk generally through a complex, polygenic pattern of inheritance rather than any single, deterministic genetic _____.

## 1.4.3 the prefrontal cortex and executive functioning

### A region central to judgement, planning, and self-regulation

The **prefrontal cortex**, discussed throughout this Part, plays a genuinely central role in **executive functioning**, including planning, judgement, impulse control, and emotional regulation, with dysfunction within this specific region implicated across a genuinely wide range of psychiatric conditions, including mood, psychotic, and personality disorders discussed further in later Series of this course.

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This central role, discussed earlier in this sub-Part, means understanding prefrontal cortex function provides a genuinely valuable conceptual bridge between specific neuroscientific findings and the clinical presentation of impaired judgement, poor impulse control, or emotional dysregulation observed across several distinct psychiatric conditions.

**Fill in the blank:** The prefrontal cortex plays a genuinely central role in executive functioning, including planning, judgement, impulse control, and emotional _____.

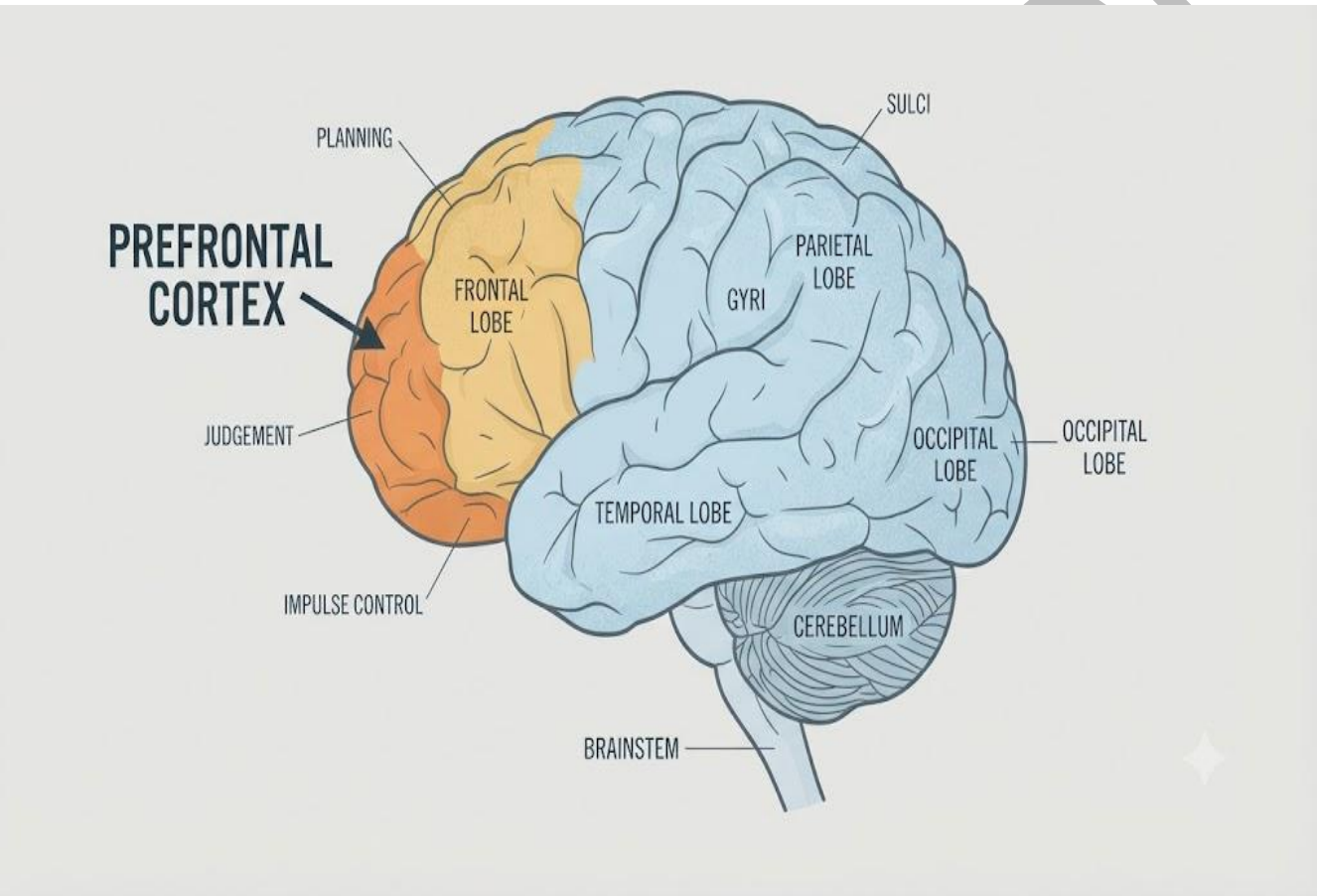


Figure 1.4: A diagram illustrating the prefrontal cortex and its role in executive functioning within the broader neural network.

**Pilot questions 1.4**

1. Describe the role of neural networks and neurotransmitters in psychiatric disorders. (Linked to SLO 1.6)
2. Explain how neurotransmitter understanding underpins psychopharmacological treatment. (Linked to SLO 1.6)
3. Define brain plasticity and its relevance to psychiatric illness. (Linked to SLO 1.7)

4. Describe the pattern of genetic contribution to psychiatric illness risk. (Linked to SLO 1.7)
5. Describe the role of the prefrontal cortex in executive functioning. (Linked to SLO 1.8)

# 1.5 Neurophysiology of Integrated Behaviour

## 1.5.1 neurophysiological basis of integrated behaviour

### Coordinated neural activity producing coherent behaviour

**Integrated behaviour**, discussed throughout this Part, reflects the coordinated activity of multiple distinct brain regions and neural networks, discussed earlier in this Series, working together to produce genuinely coherent, adaptive responses to the environment, rather than any single isolated brain region acting entirely alone.

Understanding this genuinely integrated, networked nature of normal behaviour, discussed earlier in this sub-Part, provides essential context for understanding how psychiatric disorders, discussed throughout this course, frequently reflect disruption of this normal coordination rather than isolated dysfunction confined to any single specific brain region.

**Fill in the blank:** Integrated behaviour reflects the coordinated activity of multiple distinct brain regions and neural networks working together to produce genuinely coherent, adaptive responses to the _____.

## 1.5.2 linking neuroscience to clinical presentation

### Connecting biological mechanism to observable symptom

Linking specific neuroscientific findings, discussed throughout this Series, to observable clinical presentation, discussed further in later Series of this course, allows the clinician to understand psychiatric symptoms as genuinely meaningful manifestations of underlying neurobiological dysfunction, rather than as arbitrary or purely behavioural phenomena disconnected from biological mechanism.

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This conceptual link, discussed earlier in this sub-Part, supports genuinely more sophisticated clinical reasoning, since understanding the specific neurobiological mechanism underlying a given symptom can meaningfully inform both diagnostic formulation and rational treatment selection, meaning neuroscience genuinely underpins, rather than operating separately from, everyday clinical psychiatric practice.

**Fill in the blank:** Linking neuroscientific findings to observable clinical presentation allows the clinician to understand psychiatric symptoms as genuinely meaningful manifestations of underlying neurobiological _____.

## 1.5.3 the biological foundation of human behaviour as a unifying framework

### Closing this Series' arc from history to biological mechanism

The **biological foundation of human behaviour**, discussed throughout this Series, provides a genuinely unifying conceptual framework connecting the historical, aetiological, and ethical themes examined earlier in this Series with the specific neuroscientific content examined in this final Part, together establishing the comprehensive foundation this entire course builds upon.

Appreciating this genuine unity, discussed earlier in this sub-Part, supports a genuinely coherent, integrated understanding of psychiatric illness carried forward throughout the remainder of this course, meaning the specific disorders examined in later Series should genuinely be understood against this same biopsychosocial and neurobiological foundation established here.

**Fill in the blank:** The biological foundation of human behaviour provides a genuinely unifying conceptual framework connecting the historical, aetiological, and ethical themes examined earlier in this Series with the specific _____ content examined in this final Part.

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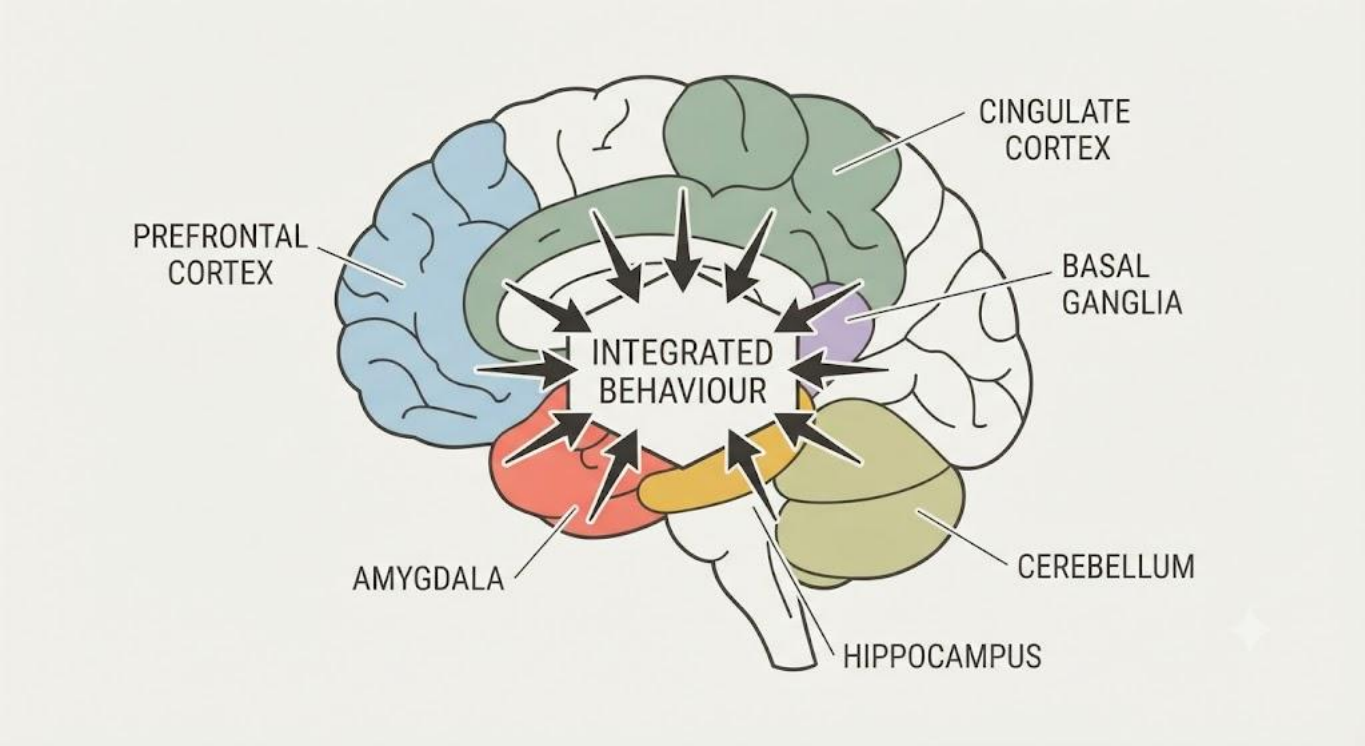


Figure 1.5: A diagram illustrating how coordinated activity across multiple brain regions produces integrated behaviour.

**Pilot questions 1.5**

- Describe the neurophysiological basis of integrated behaviour. (Linked to SLO 1.9)
- Explain how psychiatric disorders can reflect disruption of normal behavioural integration. (Linked to SLO 1.9)
- Explain the value of linking neuroscience to clinical presentation. (Linked to SLO 1.9)
- Describe how understanding neurobiological mechanism can inform treatment selection. (Linked to SLO 1.9)
- Explain how the biological foundation of human behaviour unifies the themes of this Series. (Linked to SLO 1.10)

*Series Summary*

This opening Series worked through the history and definition of psychiatry, historical milestones, disciplinary definition, and the biopsychosocial model, aetiological factors and hypotheses in mental illness, biological, psychological, and social, ethics in psychiatry, core

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principles, confidentiality, capacity, and involuntary treatment, the neuroscience of psychiatric disorders, neurotransmitters, plasticity, genetics, and the prefrontal cortex, and concluded with the neurophysiology of integrated behaviour, establishing the biological foundation of human behaviour as a unifying framework for this entire course.

This foundation carries directly into classification, psychopathology, and psychiatric assessment, examined in the next Series of this course.

### *Glossary of Terms*

- **Moral treatment movement:** a nineteenth-century reform replacing custodial confinement with humane, therapeutic psychiatric care.
- **Deinstitutionalisation:** the mid-twentieth-century shift of psychiatric care from asylums toward community settings.
- **Biopsychosocial model:** a framework recognising biological, psychological, and social factors together in mental illness.
- **Autonomy:** a bioethical principle respecting a patient's own right to make informed decisions about their care.
- **Capacity:** a patient's ability to understand, retain, and weigh relevant information to reach a decision.
- **Involuntary treatment:** treatment provided without patient consent under specific legal and ethical safeguards.
- **Neurotransmitter:** a chemical messenger communicating signals between neurons within neural networks.
- **Brain plasticity:** the brain's capacity for structural and functional reorganisation in response to experience.
- **Polygenic inheritance:** a pattern of genetic risk involving many genes of small individual effect.
- **Prefrontal cortex:** a brain region central to planning, judgement, impulse control, and emotional regulation.
- **Executive functioning:** higher-order cognitive processes including planning, judgement, and self-regulation.
- **Integrated behaviour:** coherent, adaptive behaviour arising from coordinated activity across multiple brain regions.

### *Concept Check Questions [Series 1]*

**Objective questions**

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1. Psychiatry's historical development includes the moral treatment movement, replacing custodial confinement with a more humane, therapeutic _____.
2. The biopsychosocial model recognises that mental illness generally results from the combined interaction of biological, psychological, and social factors rather than any single domain acting in genuine _____.
3. The standard bioethical principles apply to psychiatric practice with particular weight, since psychiatric disorders can themselves genuinely affect a patient's own capacity for autonomous _____.
4. Genetics contributes meaningfully to psychiatric illness risk generally through a complex, polygenic pattern of inheritance rather than any single, deterministic genetic _____.
5. The prefrontal cortex plays a genuinely central role in executive functioning, including planning, judgement, impulse control, and emotional _____.

**Short-answer questions**

6. Define psychiatry as a medical discipline.
7. List the three domains of the biopsychosocial model.
8. List the standard bioethical principles applied to psychiatry.
9. Define capacity and its relevance to psychiatric ethics.
10. Describe the role of the prefrontal cortex in executive functioning.

**Long-answer questions**

11. Discuss key historical milestones in psychiatry and the biopsychosocial model. (Linked to SLO 1.1, SLO 1.2)
12. Discuss biological, psychological, and social factors in the causation of mental illness. (Linked to SLO 1.3)
13. Discuss the principles of medical ethics applied to psychiatry, confidentiality, capacity, and involuntary treatment. (Linked to SLO 1.4, SLO 1.5)
14. Discuss neural networks, neurotransmitters, brain plasticity, genetics, and the prefrontal cortex. (Linked to SLO 1.6, SLO 1.7, SLO 1.8)
15. Discuss the neurophysiology of integrated behaviour and the biological foundation of human behaviour. (Linked to SLO 1.9, SLO 1.10)

*Answers to Concept Check Questions [Series 1]*

**Objective questions**

1. Model.
2. Isolation.

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3. Decision-making.
4. Cause.
5. Regulation.

**Short-answer questions**

6. The medical specialty concerned with the diagnosis, treatment, and prevention of mental, emotional, and behavioural disorders.
7. Biological, psychological, and social.
8. Autonomy, beneficence, non-maleficence, and justice.
9. The ability to understand, retain, and weigh relevant information to reach a decision; central to informed consent and involuntary treatment decisions.
10. It plays a central role in planning, judgement, impulse control, and emotional regulation.

**Long-answer questions**

11. **Basic response:** Psychiatric history spans from moral treatment reform through deinstitutionalisation to modern evidence-based practice.

**Value-added response:** The biopsychosocial model provides the foundational framework recognising biological, psychological, and social contributions together.

12. **Basic response:** Biological, psychological, and social factors each contribute to mental illness causation, generally in combination rather than isolation.

**Value-added response:** This multifactorial understanding directly informs comprehensive, biopsychosocial treatment planning.

13. **Basic response:** Standard bioethical principles apply to psychiatry with particular complexity given capacity considerations.

**Value-added response:** Confidentiality, capacity assessment, and safeguarded involuntary treatment together require careful, individualised ethical judgement.

14. **Basic response:** Neural networks and neurotransmitters underpin mood and cognition, with brain plasticity and genetics shaping vulnerability.

**Value-added response:** The prefrontal cortex's role in executive functioning links neuroscience directly to clinical presentation across several disorders.

15. **Basic response:** Integrated behaviour reflects coordinated activity across multiple brain regions rather than isolated function.

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**Value-added response:** This neurophysiological understanding unifies the historical, aetiological, and ethical themes of this Series into a coherent biological foundation.

*Answers to Pilot Questions [Series 1]*

**Part 1.1**

1. The moral treatment movement and mid-twentieth-century deinstitutionalisation, among further developments such as formal classification and effective pharmacotherapy.
2. It replaced custodial confinement with a more humane, therapeutic model of care.
3. The medical specialty concerned with the diagnosis, treatment, and prevention of mental, emotional, and behavioural disorders.
4. A framework recognising biological, psychological, and social factors together in mental illness causation and treatment.
5. Because a comprehensive formulation must consider contributing factors from each of the three domains rather than any one alone.

**Part 1.2**

1. Genetic predisposition, neurotransmitter dysregulation, and structural or functional brain abnormality.
2. Because environmental and psychological factors frequently interact with underlying biological vulnerability.
3. Maladaptive cognitive patterns, early developmental experience, and personality vulnerability.
4. Socioeconomic adversity, significant life stressors, and social isolation.
5. Effective management frequently requires addressing social factors alongside biological and psychological treatment.

**Part 1.3**

1. Autonomy, beneficence, non-maleficence, and justice.
2. Because psychiatric disorders can themselves affect a patient's capacity for autonomous decision-making.
3. The ability to understand, retain, and weigh relevant information to reach a genuine decision.
4. A patient lacking capacity may require disclosure to family that would otherwise breach standard confidentiality.

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5. Formal capacity assessment, independent review, and use of the least restrictive intervention necessary.

**Part 1.4**

1. They provide the essential biological substrate for mood, cognition, and behaviour, with dysregulation implicated across many disorders.
2. Most psychotropic medications act by modulating these same neurotransmitter systems in a targeted way.
3. The brain's capacity for structural and functional reorganisation in response to experience; it offers both a mechanism of illness and a therapeutic target.
4. A complex, polygenic pattern of inheritance rather than any single, deterministic genetic cause.
5. It plays a central role in planning, judgement, impulse control, and emotional regulation.

**Part 1.5**

- Coordinated activity of multiple distinct brain regions and neural networks working together to produce coherent, adaptive responses.
- Psychiatric disorders frequently reflect disruption of this normal coordination rather than isolated dysfunction in one region.
- It allows symptoms to be understood as meaningful manifestations of underlying neurobiological dysfunction rather than arbitrary phenomena.
- Understanding the specific mechanism underlying a symptom can inform both diagnostic formulation and rational treatment selection.
- It connects the historical, aetiological, and ethical themes with the neuroscientific content into a coherent biological foundation.

*References and Attributions [Series 1]*


- Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
- Semple, D., & Smyth, R. (2019). Oxford Handbook of Psychiatry (4th ed.). Oxford University Press.
- Shorter, E. (1997). A History of Psychiatry: From the Era of the Asylum to the Age of Prozac. Wiley.
- Kandel, E. R., et al. (2021). Principles of Neural Science (6th ed.). McGraw-Hill.


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**Figures, Plates, Tables, and Boxes**

- Figure 1.1: A diagram illustrating the biopsychosocial model, showing the interaction of biological, psychological, and social domains in mental illness. AI-generated using the prompt: "A single clean, accurate schematic Venn diagram with three overlapping circles labelled Biological, Psychological, and Social, with a central overlapping region labelled Mental Illness, textbook psychiatry diagram style, neutral background, no photographic realism, no other panels."
- Table 1.2: The three domains of the biopsychosocial model. AI-generated using the prompt: "Create a clean clinical reference table titled The Three Domains of the Biopsychosocial Model, listing domain, example factor, and clinical relevance. Medical reference table style with outside border, no photographic elements."
- Figure 1.4: A diagram illustrating the prefrontal cortex and its role in executive functioning within the broader neural network. AI-generated using the prompt: "A single clean, accurate lateral schematic diagram of the human brain with the prefrontal cortex region clearly highlighted and labelled, with small annotation labels indicating planning, judgement, and impulse control, textbook neuroscience diagram style, neutral background, no photographic realism, no other panels."
- Figure 1.5: A diagram illustrating how coordinated activity across multiple brain regions produces integrated behaviour. AI-generated using the prompt: "A single clean, accurate schematic diagram of the brain showing several labelled regions connected by directional arrows converging toward a central label reading Integrated Behaviour, textbook neuroscience diagram style, neutral background, no photographic realism, no other panels."

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**Course code: PSY 601**

**Course title: General Psychiatry**

**Course credit load: 3 Units**

# Series 2: Classification, Psychopathology, and Psychiatric Assessment

- **Part 2.1: Classification of Psychiatric Disorders**
  - Sub Part 2.1.1: Principles of psychiatric classification
  - Sub Part 2.1.2: The ICD classification system
  - Sub Part 2.1.3: The DSM classification system
- **Part 2.2: Psychopathology of Perception and Thought**
  - Sub Part 2.2.1: Disorders of perception
  - Sub Part 2.2.2: Disorders of thought
  - Sub Part 2.2.3: Disorders of speech
- **Part 2.3: Psychopathology of Emotion, Self, and Consciousness**
  - Sub Part 2.3.1: Disorders of emotion
  - Sub Part 2.3.2: Disorders of the experience of the self
  - Sub Part 2.3.3: Disorders of consciousness
- **Part 2.4: Psychiatric History Taking and Mental State Examination**
  - Sub Part 2.4.1: Psychiatric history taking
  - Sub Part 2.4.2: The mental state examination
  - Sub Part 2.4.3: Physical examination in relation to psychiatry
- **Part 2.5: Psychological Assessment and Specialised Interview Contexts**
  - Sub Part 2.5.1: Psychological assessment: neuropsychological, cognitive, behavioural, personality
  - Sub Part 2.5.2: Interview in emergency settings
  - Sub Part 2.5.3: Interview in general practice

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# Introduction

Before any specific psychiatric disorder can be meaningfully discussed, a clinician needs two genuinely fundamental tools, a shared, standardised **classification** system for naming and organising mental disorders, and the descriptive vocabulary of **psychopathology** for accurately capturing what a patient is actually experiencing. This Series builds both, working through the **classification of psychiatric disorders**, the **psychopathology of perception and thought**, the **psychopathology of emotion, self, and consciousness**, and, finally, the practical skills of **psychiatric history taking, mental state examination**, and **psychological assessment** across a range of clinical contexts.

The aim of this Series is to equip you with a thorough understanding of applying ICD and DSM classification to mental disorders, the phenomenological description of psychopathology, and the practical conduct of psychiatric history taking, mental state examination, and psychological assessment.

This Series begins with **classification of psychiatric disorders**, before turning to **psychopathology of perception and thought**, **psychopathology of emotion, self, and consciousness**, and **psychiatric history taking and mental state examination**. It concludes with **psychological assessment and specialised interview contexts**.

# Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 2.1:** describe the principles of psychiatric classification and the ICD and DSM systems
- **SLO 2.2:** apply ICD and DSM in classifying mental disorders
- **SLO 2.3:** describe disorders of perception, thought, and speech
- **SLO 2.4:** describe disorders of emotion, the experience of the self, and consciousness
- **SLO 2.5:** conduct psychiatric history taking
- **SLO 2.6:** conduct the mental state examination and physical examination in relation to psychiatry
- **SLO 2.7:** describe neuropsychological, cognitive, behavioural, and personality assessment
- **SLO 2.8:** conduct a psychiatric interview in an emergency setting
- **SLO 2.9:** conduct a psychiatric interview in general practice, and
- **SLO 2.10:** compare specialised interview contexts across clinical settings.

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## 2.1 Classification of Psychiatric Disorders

### 2.1.1 principles of psychiatric classification

***Why a shared diagnostic language genuinely matters***

**Psychiatric classification**, discussed throughout this Series, provides a shared, standardised diagnostic language allowing clinicians, researchers, and health systems to communicate reliably about specific mental disorders, supporting consistent diagnosis, meaningful research comparison, and coordinated treatment planning across genuinely different clinical settings.

Modern classification systems, discussed further in the next two sub-Parts, generally rely on **descriptive**, symptom-based criteria rather than presumed underlying cause, reflecting the genuine reality that the specific aetiology of most psychiatric disorders, discussed in the previous Series of this course, remains incompletely understood despite considerable ongoing research.

**Fill in the blank:** Psychiatric classification provides a shared, standardised diagnostic language allowing clinicians, researchers, and health systems to communicate reliably about specific mental _____.

### 2.1.2 the icd classification system

***The World Health Organization's international standard***

The **International Classification of Diseases (ICD)**, discussed throughout this Part, published by the World Health Organization, provides the internationally recognised classification system for mental and behavioural disorders, generally used globally for both clinical practice and health system reporting given its genuinely broad, worldwide adoption.

The ICD's specific diagnostic criteria, discussed earlier in this sub-Part, are periodically revised to reflect evolving clinical and research understanding, meaning clinicians must remain genuinely familiar with the current, applicable version of this classification system rather than relying on outdated or superseded diagnostic criteria.

**Fill in the blank:** The International Classification of Diseases, published by the World Health Organization, provides the internationally recognised classification system for mental and behavioural _____.

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## 2.1.3 the dsm classification system

***The predominant classification standard in North American practice***

The **Diagnostic and Statistical Manual of Mental Disorders (DSM)**, discussed throughout this Part, published by the American Psychiatric Association, provides a further widely used classification system, particularly predominant within North American clinical and research practice, sharing considerable overlap with, though not perfect identity to, the ICD system discussed earlier in this Series.

Genuine familiarity with both systems, discussed earlier in this sub-Part, allows the clinician to engage confidently with international research literature and clinical guidelines regardless of which specific classification framework a given source happens to use, meaning competent modern psychiatric practice genuinely requires working knowledge of both major systems.

**Fill in the blank:** The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, shares considerable overlap with, though not perfect identity to, the _____ system.

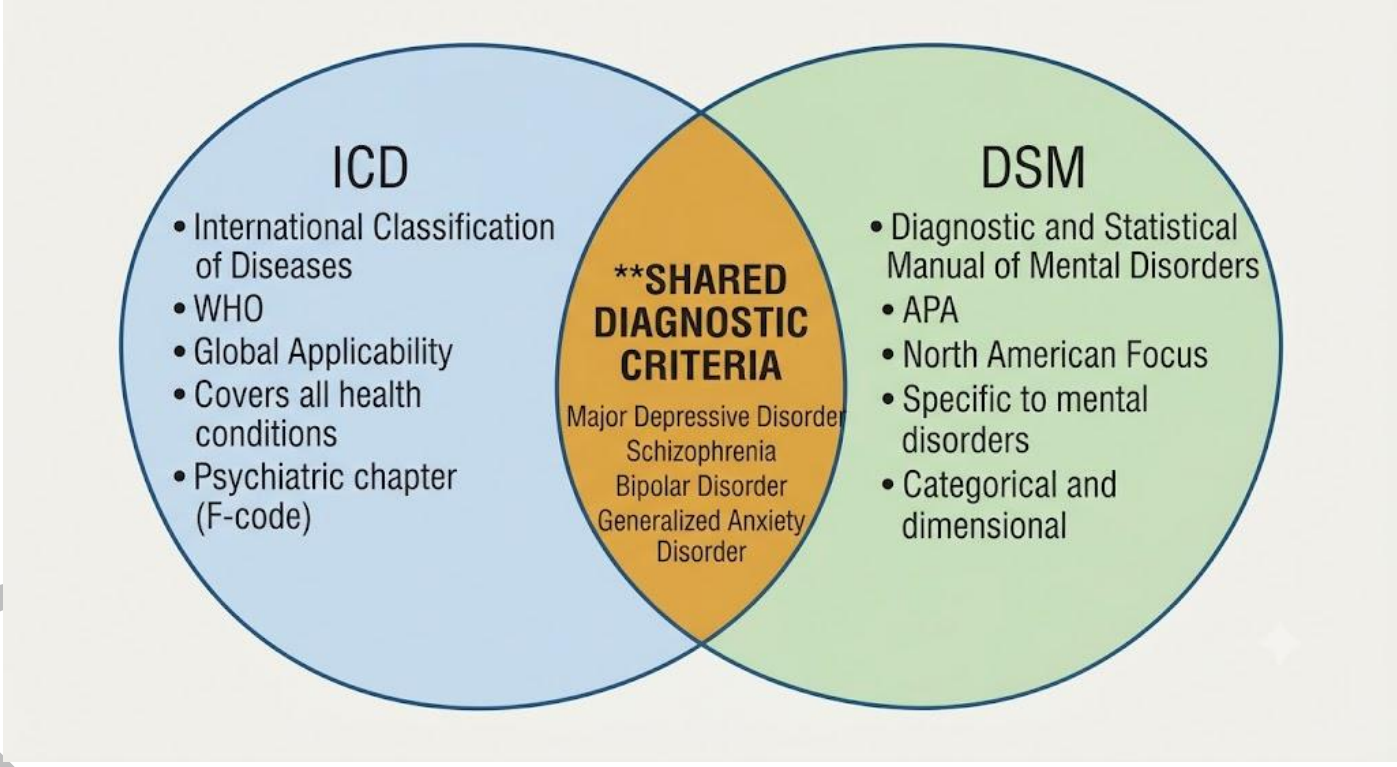


Figure 2.1: A diagram comparing the ICD and DSM classification systems and their overlapping diagnostic scope.

Pilot questions 2.1

- Explain the purpose of psychiatric classification. (Linked to SLO 2.1)
- Explain why modern classification systems rely on descriptive, symptom-based criteria. (Linked to SLO 2.1)
- Describe the ICD classification system. (Linked to SLO 2.1)
- Describe the DSM classification system. (Linked to SLO 2.2)
- Explain why familiarity with both ICD and DSM is valuable for modern psychiatric practice. (Linked to SLO 2.2)

## 2.2 Psychopathology of Perception and Thought

### 2.2.1 disorders of perception

***When sensory experience itself becomes genuinely disturbed***

**Disorders of perception**, discussed throughout this Part, include **hallucinations**, genuine perceptual experiences occurring without any corresponding external stimulus, and **illusions**, a genuine misperception of an actual, present external stimulus, each distinguished by the patient's own perception being experienced as genuinely real despite lacking an accurate corresponding external basis.

Hallucinations, discussed earlier in this sub-Part, can occur across essentially any sensory modality, auditory, visual, tactile, olfactory, or gustatory, with the specific modality and content frequently carrying genuine diagnostic significance, discussed further in later Series of this course, toward the likely underlying psychiatric or medical condition.

**Fill in the blank:** Hallucinations are genuine perceptual experiences occurring without any corresponding external _____.

### 2.2.2 disorders of thought

***Disturbances of both thought content and thought form***

**Disorders of thought**, discussed throughout this Part, are broadly divided into disturbances of **thought content**, including delusions, genuinely fixed, false beliefs held with conviction despite clear contrary evidence, and disturbances of **thought form**, including disorganised or illogical patterns of thinking reflected in the patient's own speech.

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**Delusions**, discussed earlier in this sub-Part, are further classified by their specific content, including persecutory, grandiose, or referential themes, each carrying distinct diagnostic relevance discussed further in relation to psychotic disorders in a later Series of this course, meaning careful, accurate characterisation of delusional content represents an essential clinical skill.

**Fill in the blank:** Delusions are genuinely fixed, false beliefs held with conviction despite clear contrary _____.

## 2.2.3 disorders of speech

***Speech as the observable window onto thought form***

**Disorders of speech**, discussed in relation to thought form earlier in this Part, provide the clinician's most direct, observable window onto a patient's underlying thought process, since disorganised speech, including loosening of associations, tangentiality, or word salad, generally reflects genuine, corresponding disorganisation of thought itself.

Careful, systematic observation of speech pattern, discussed earlier in this sub-Part, together with content, forms an essential component of the mental state examination, discussed further later in this Series, meaning accurate speech assessment represents a genuinely important, practical clinical skill rather than a purely academic descriptive exercise.

**Fill in the blank:** Careful, systematic observation of speech pattern, together with content, forms an essential component of the mental state _____.

**Table 2.2: Comparing disorders of perception, thought, and speech.**

| Domain | Example finding | Key feature |
|---|---|---|
| Perception | Hallucination | Perceptual experience without external stimulus |
| Thought content | Delusion | Fixed, false belief held despite contrary evidence |
| Speech (thought form) | Loosening of associations | Observable reflection of underlying disorganised thinking |

**Pilot questions 2.2**

1. Define hallucination and illusion. (Linked to SLO 2.3)

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2. List sensory modalities across which hallucinations can occur. (Linked to SLO 2.3)
3. Distinguish disturbances of thought content from disturbances of thought form. (Linked to SLO 2.3)
4. Define delusion and list example delusional themes. (Linked to SLO 2.3)
5. Explain why speech observation is central to assessing thought form. (Linked to SLO 2.3)

## 2.3 Psychopathology of Emotion, Self, and Consciousness

### 2.3.1 disorders of emotion

***Distinguishing subjective mood from observed affect***

**Disorders of emotion**, discussed throughout this Part, are generally described using two related but genuinely distinct terms, **mood**, the patient's own reported, subjective, sustained emotional state, and **affect**, the clinician's own objective, observed emotional expression during the assessment itself, with the specific relationship between these two carrying genuine diagnostic significance.

A genuine **mismatch** between reported mood and observed affect, discussed earlier in this sub-Part, such as a patient describing themselves as happy while displaying flat, unemotional affect, represents an important recognised finding, discussed further in relation to specific disorders in later Series of this course, warranting careful further clinical exploration.

**Fill in the blank:** Mood is the patient's own reported, subjective, sustained emotional state, while affect is the clinician's own objective, observed emotional _____.

### 2.3.2 disorders of the experience of the self

***Disturbances of one's own genuine sense of identity***

**Disorders of the experience of the self**, discussed throughout this Part, include **depersonalisation**, a genuine, distressing sense of detachment or unreality regarding one's own self, and **derealisation**, a similar sense of unreality applied instead to the surrounding external environment, each reflecting genuine disturbance in how the patient experiences their own relationship to themselves or their world.

These specific phenomena, discussed earlier in this sub-Part, can occur transiently in genuinely non-pathological states, including extreme fatigue or stress, or as a genuinely persistent,

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distressing symptom within several recognised psychiatric conditions, discussed further in later Series of this course, meaning careful clinical context remains essential to accurate interpretation.

**Fill in the blank:** Depersonalisation is a genuine, distressing sense of detachment or unreality regarding one's own _____.

## 2.3.3 disorders of consciousness

***Disturbances of overall arousal and awareness***

**Disorders of consciousness**, discussed throughout this Part, range from mild clouding of consciousness, reduced clarity of thinking and awareness, through to **delirium**, an acute, fluctuating disturbance of consciousness and attention, discussed in relation to critical illness in related coursework, generally reflecting an underlying, genuinely organic medical cause requiring careful, prompt investigation.

Distinguishing disorders of consciousness from primary psychiatric conditions, discussed earlier in this sub-Part, carries genuine clinical urgency, since delirium specifically frequently reflects an underlying, treatable medical cause, meaning careful assessment of consciousness represents an essential, safety-critical component of every thorough psychiatric evaluation.

**Fill in the blank:** Delirium is an acute, fluctuating disturbance of consciousness and attention, generally reflecting an underlying, genuinely organic medical cause requiring careful, prompt _____.

**Table 2.3: Comparing key disorders of emotion, self, and consciousness.**

| Term | Description | Clinical relevance |
|---|---|---|
| Mood versus affect | Subjective reported state versus observed expression | Mismatch carries diagnostic significance |
| Depersonalisation | Detachment from one's own sense of self | May occur transiently or as persistent symptom |
| Delirium | Acute, fluctuating disturbance of consciousness | Frequently reflects an underlying organic medical cause |

Pilot questions 2.3

1. Distinguish mood from affect. (Linked to SLO 2.4)

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2. Explain the diagnostic significance of a mismatch between mood and affect. (Linked to SLO 2.4)
3. Distinguish depersonalisation from derealisation. (Linked to SLO 2.4)
4. Define delirium. (Linked to SLO 2.4)
5. Explain why distinguishing delirium from primary psychiatric conditions carries genuine clinical urgency. (Linked to SLO 2.4)

## 2.4 Psychiatric History Taking and Mental State Examination

### 2.4.1 psychiatric history taking

***A structured, comprehensive approach to the patient's own story***

**Psychiatric history taking**, discussed throughout this Part, follows a genuinely structured sequence, presenting complaint, history of presenting complaint, past psychiatric history, past medical history, family history, personal and social history, and premorbid personality, together building a comprehensive, contextualised understanding of the patient's own current presentation.

This structured approach, discussed earlier in this sub-Part, ensures genuinely comprehensive information gathering while allowing the clinician sufficient flexibility to follow the patient's own specific, individual narrative, meaning skilled psychiatric history taking combines systematic thoroughness with genuine, attentive clinical listening.

**Fill in the blank:** Psychiatric history taking follows a genuinely structured sequence, together building a comprehensive, contextualised understanding of the patient's own current _____.

### 2.4.2 the mental state examination

***A structured snapshot of the patient's current psychological state***

The **mental state examination**, discussed in relation to psychopathology established earlier in this Series, provides a structured, systematic snapshot of the patient's current psychological state, examining appearance and behaviour, speech, mood and affect, thought, perception, cognition, and insight, in a consistent, reproducible sequence.

This structured examination, discussed earlier in this sub-Part, directly applies the descriptive psychopathological vocabulary established earlier in this Series, meaning genuine competence in

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the mental state examination depends considerably on prior, thorough familiarity with these specific descriptive terms and their accurate clinical application.

**Fill in the blank:** The mental state examination provides a structured, systematic snapshot of the patient's current psychological state, examining appearance and behaviour, speech, mood and affect, thought, perception, cognition, and _____.

## 2.4.3 physical examination in relation to psychiatry

***Excluding genuine organic contributors to presentation***

**Physical examination** in relation to psychiatry, discussed throughout this Part, remains a genuinely essential component of comprehensive psychiatric assessment, since certain medical conditions can present with prominent psychiatric symptoms, discussed further in relation to delirium earlier in this Series, meaning thorough psychiatric assessment should never entirely omit physical examination.

This examination, discussed earlier in this sub-Part, generally includes attention to vital signs, neurological examination, and screening for medical conditions genuinely relevant to the specific presenting psychiatric complaint, meaning the psychiatric clinician must genuinely retain and apply broader medical assessment skills alongside specific psychiatric expertise.

**Fill in the blank:** Physical examination remains a genuinely essential component of comprehensive psychiatric assessment, since certain medical conditions can present with prominent psychiatric _____.

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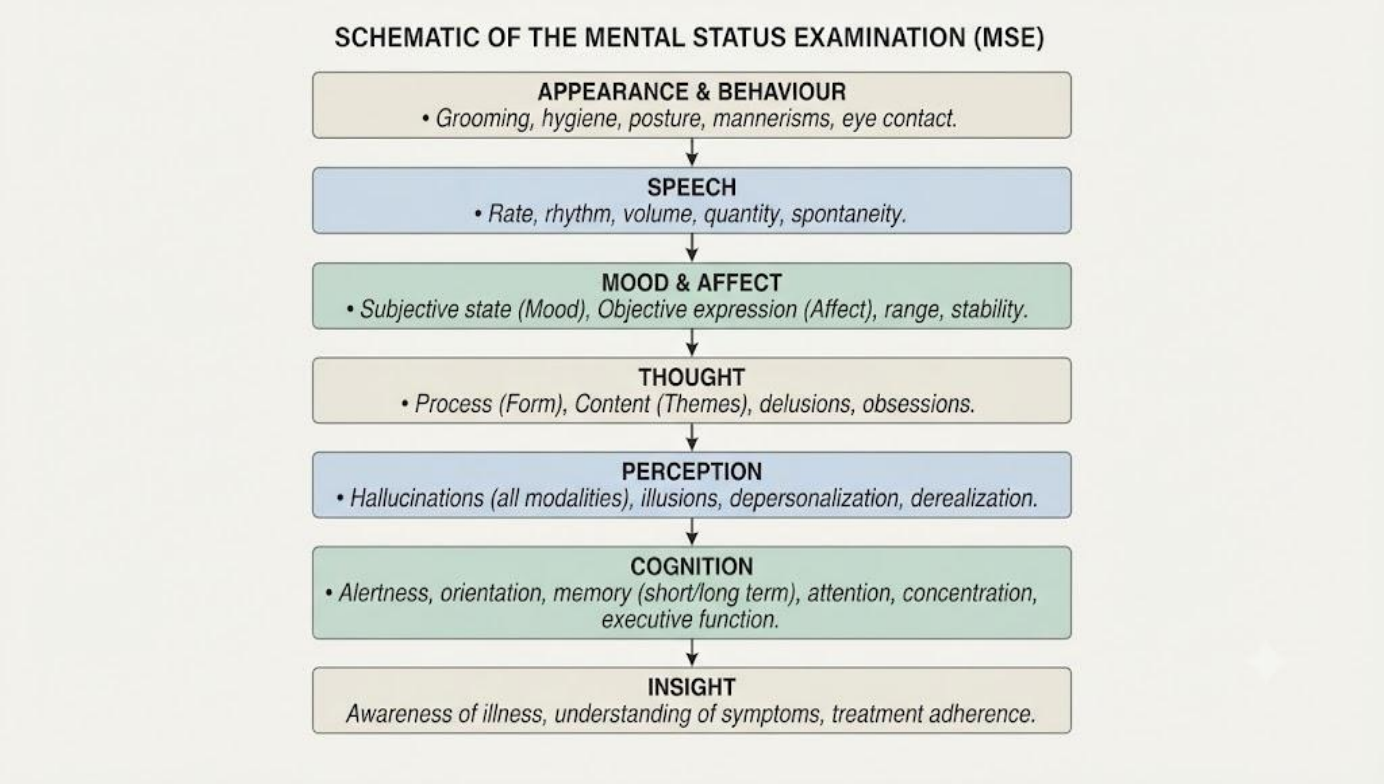


Figure 2.4: A diagram illustrating the structured components of a comprehensive mental state examination.

**Pilot questions 2.4**

1. List the components of a structured psychiatric history. (Linked to SLO 2.5)
2. Explain why structured history taking combines thoroughness with flexibility. (Linked to SLO 2.5)
3. List the components of the mental state examination. (Linked to SLO 2.6)
4. Explain why competence in psychopathological vocabulary supports the mental state examination. (Linked to SLO 2.6)
5. Explain why physical examination remains essential in psychiatric assessment. (Linked to SLO 2.6)

## 2.5 Psychological Assessment and Specialised Interview Contexts

### 2.5.1 psychological assessment: neuropsychological, cognitive, behavioural, personality

***Formal tools complementing clinical interview and examination***

**Psychological assessment**, discussed throughout this Part, encompasses several genuinely distinct assessment domains, **neuropsychological** assessment, examining specific cognitive domains in detail, **cognitive** screening tools, **behavioural** assessment, and **personality** assessment, each offering structured, standardised information complementing the clinical interview and examination discussed earlier in this Series.

These formal assessment tools, discussed earlier in this sub-Part, carry particular value where diagnostic uncertainty remains following standard clinical assessment, or where genuinely detailed, quantified characterisation of a specific cognitive or personality domain is required, meaning psychological assessment represents a valuable, though generally complementary rather than replacement, clinical tool.

**Fill in the blank:** Psychological assessment encompasses neuropsychological, cognitive, behavioural, and personality assessment, each offering structured, standardised information complementing the clinical interview and _____.

## 2.5.2 interview in emergency settings

***Rapid, focused assessment under genuine time pressure***

**Interview in emergency settings**, discussed throughout this Part, requires the clinician to conduct a genuinely rapid, focused assessment, prioritising immediate safety concerns, including suicide or violence risk, discussed further in a later Series of this course, over the more comprehensive, unhurried history taking approach discussed earlier in this Series.

This modified approach, discussed earlier in this sub-Part, reflects the genuinely urgent priorities of the emergency setting, meaning the emergency psychiatric interview should genuinely be understood as a distinct clinical skill, deliberately adapted from standard history taking principles rather than simply an abbreviated version of the same.

**Fill in the blank:** Interview in emergency settings requires the clinician to conduct a genuinely rapid, focused assessment, prioritising immediate safety concerns, including suicide or violence _____.

## 2.5.3 interview in general practice

***Recognising psychiatric presentation within a broader medical context***

**Interview in general practice**, discussed throughout this Part, requires genuine skill in recognising psychiatric presentation occurring within a broader medical consultation, frequently

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presenting with predominantly physical, somatic complaints rather than explicitly psychological symptoms, given the genuinely common tendency for mental distress to present through physical channels in this specific setting.

This specific skill, discussed earlier in this sub-Part, requires genuine sensitivity to subtle cues suggesting an underlying psychiatric contribution, meaning effective general practice psychiatric assessment demands a somewhat different clinical orientation from the specialist psychiatric settings discussed throughout the remainder of this Series.

**Fill in the blank:** Interview in general practice requires genuine skill in recognising psychiatric presentation occurring within a broader medical consultation, frequently presenting with predominantly physical, somatic _____.

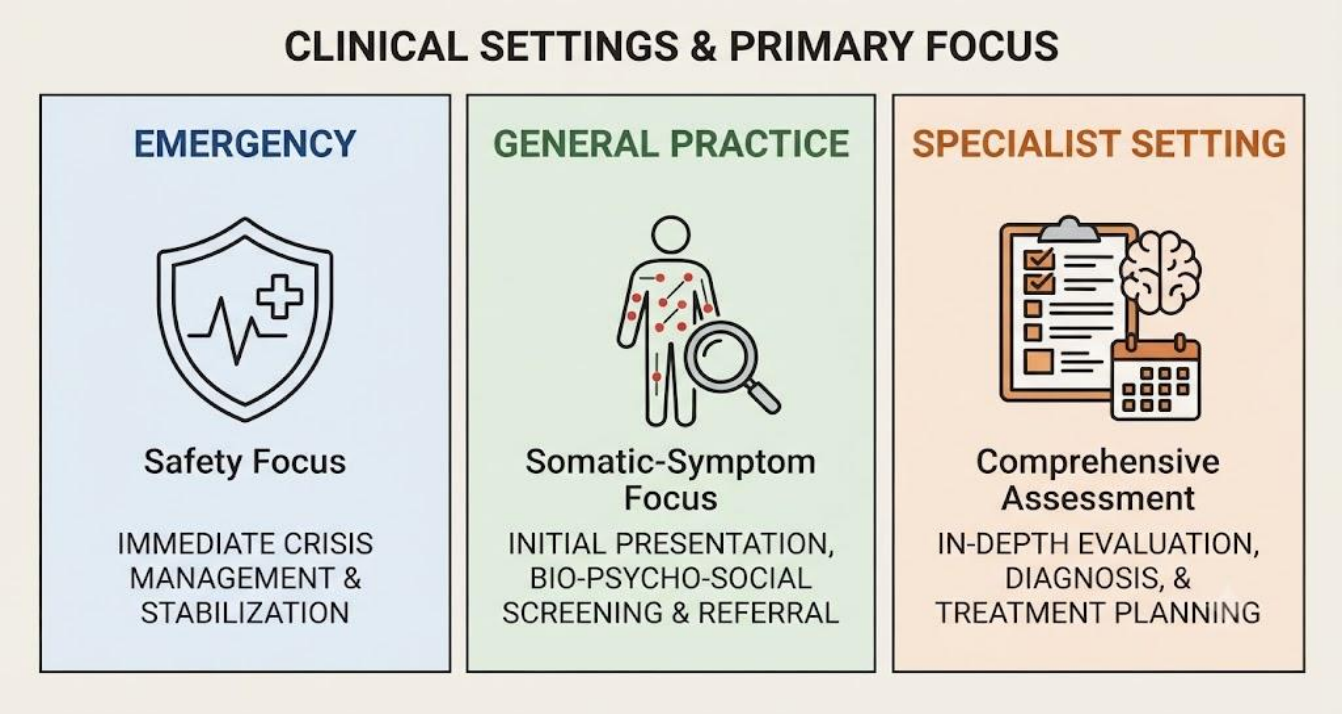


Figure 2.5: A diagram comparing the interview approach and priorities in emergency, general practice, and specialist psychiatric settings.

**Pilot questions 2.5**

1. List domains of psychological assessment. (Linked to SLO 2.7)
2. Explain when formal psychological assessment carries particular clinical value. (Linked to SLO 2.7)

3. Describe how interview in emergency settings differs from standard history taking. (Linked to SLO 2.8)
4. Describe why psychiatric presentation in general practice often involves somatic complaints. (Linked to SLO 2.9)
5. Compare interview approaches across emergency and general practice settings. (Linked to SLO 2.10)

**Series Summary**

This Series worked through the classification of psychiatric disorders, its principles, the ICD, and the DSM, the psychopathology of perception and thought, hallucinations, delusions, and speech disorder, the psychopathology of emotion, self, and consciousness, mood and affect, depersonalisation, and delirium, psychiatric history taking and the mental state examination, and concluded with psychological assessment and specialised interview contexts across emergency and general practice settings.

This foundation carries directly into mood disorders and schizophrenia spectrum disorders, examined in the next Series of this course.

**Glossary of Terms**

6. **ICD:** the International Classification of Diseases, published by the World Health Organization.
7. **DSM:** the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.
8. **Hallucination:** a genuine perceptual experience occurring without any corresponding external stimulus.
9. **Delusion:** a fixed, false belief held with conviction despite clear contrary evidence.
10. **Mood:** a patient's own reported, subjective, sustained emotional state.
11. **Affect:** the clinician's own observed emotional expression during assessment.
12. **Depersonalisation:** a distressing sense of detachment or unreality regarding one's own self.
13. **Delirium:** an acute, fluctuating disturbance of consciousness and attention, generally organic in origin.

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14. **Mental state examination:** a structured, systematic assessment of a patient's current psychological state.
15. **Neuropsychological assessment:** formal testing examining specific cognitive domains in detail.
16. **Emergency psychiatric interview:** a rapid, focused assessment prioritising immediate safety concerns.
17. **Somatic presentation:** psychiatric distress presenting through physical rather than explicitly psychological symptoms.

## Concept Check Questions [Series 2]

### Objective questions

- Psychiatric classification provides a shared, standardised diagnostic language allowing clinicians, researchers, and health systems to communicate reliably about specific mental _____.
- Hallucinations are genuine perceptual experiences occurring without any corresponding external _____.
- Delirium is an acute, fluctuating disturbance of consciousness and attention, generally reflecting an underlying, genuinely organic medical cause requiring careful, prompt _____.
- The mental state examination provides a structured, systematic snapshot of the patient's current psychological state, examining appearance and behaviour, speech, mood and affect, thought, perception, cognition, and _____.
- Interview in emergency settings requires the clinician to conduct a genuinely rapid, focused assessment, prioritising immediate safety concerns, including suicide or violence _____.

### Short-answer questions

1. Describe the ICD and DSM classification systems.
2. Distinguish disturbances of thought content from disturbances of thought form.
3. Distinguish mood from affect.
4. List the components of the mental state examination.
5. List domains of psychological assessment.

### Long-answer questions

6. Discuss the principles of psychiatric classification and the ICD and DSM systems. (Linked to SLO 2.1, SLO 2.2)

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7. Discuss disorders of perception, thought, and speech. (Linked to SLO 2.3)
8. Discuss disorders of emotion, the experience of the self, and consciousness. (Linked to SLO 2.4)
9. Discuss psychiatric history taking, the mental state examination, and physical examination in relation to psychiatry. (Linked to SLO 2.5, SLO 2.6)
10. Discuss psychological assessment and specialised interview contexts in emergency and general practice settings. (Linked to SLO 2.7, SLO 2.8, SLO 2.9, SLO 2.10)

**Answers to Concept Check Questions [Series 2]**

**Objective questions**

11. Disorders.
12. Stimulus.
13. Investigation.
14. Insight.
15. Risk.

**Short-answer questions**

16. The ICD is published by the WHO and used globally; the DSM is published by the APA and predominant in North American practice, with considerable overlap between them.
17. Thought content disturbance includes delusions; thought form disturbance includes disorganised or illogical thinking patterns reflected in speech.
18. Mood is the patient's own reported, subjective state; affect is the clinician's observed emotional expression.
19. Appearance and behaviour, speech, mood and affect, thought, perception, cognition, and insight.
20. Neuropsychological, cognitive, behavioural, and personality assessment.

**Long-answer questions**

21. **Basic response:** Psychiatric classification provides a shared diagnostic language, with the ICD and DSM as the two major, overlapping systems.

**Value-added response:** Both systems rely on descriptive, symptom-based criteria given incomplete understanding of underlying aetiology.

22. **Basic response:** Disorders of perception include hallucinations and illusions, while disorders of thought include disturbances of content and form.

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**Value-added response:** Speech observation provides the clinician's most direct window onto underlying thought disorganisation.

23. **Basic response:** Mood and affect, depersonalisation and derealisation, and disorders of consciousness each represent distinct psychopathological domains.

**Value-added response:** Delirium in particular carries urgency given its frequent underlying organic medical cause.

24. **Basic response:** Psychiatric history taking follows a structured sequence, while the mental state examination provides a structured current snapshot.

**Value-added response:** Physical examination remains essential given the potential for medical conditions to present with psychiatric symptoms.

25. **Basic response:** Psychological assessment offers formal, standardised tools complementing clinical interview and examination.

**Value-added response:** Emergency and general practice interview contexts each demand distinct, adapted clinical approaches reflecting their specific settings.

**Answers to Pilot Questions [Series 2]**

**Part 2.1**

1. It provides a shared, standardised diagnostic language supporting consistent diagnosis and communication.
2. Because the specific aetiology of most disorders remains incompletely understood.
3. The internationally recognised WHO classification system for mental and behavioural disorders.
4. The APA-published classification system predominant in North American practice.
5. It allows engagement with international literature and guidelines regardless of which system a source uses.

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**Part 2.2**

6. Hallucination is a perception without external stimulus; illusion is a misperception of an actual stimulus.
7. Auditory, visual, tactile, olfactory, and gustatory.
8. Thought content concerns what is believed (e.g. delusions); thought form concerns how thinking is structured or organised.
9. A fixed, false belief held with conviction despite contrary evidence; examples include persecutory, grandiose, and referential themes.
10. Because disorganised speech generally reflects genuine, corresponding disorganisation of underlying thought.

**Part 2.3**

11. Mood is the patient's subjective reported state; affect is the clinician's observed expression.
12. A mismatch between the two represents an important recognised finding warranting further exploration.
13. Depersonalisation is detachment from one's own self; derealisation is a similar sense of unreality applied to the external environment.
14. An acute, fluctuating disturbance of consciousness and attention, generally organic in origin.
15. Because delirium frequently reflects an underlying, treatable medical cause requiring prompt investigation.

**Part 2.4**

1. Presenting complaint, history of presenting complaint, past psychiatric and medical history, family history, personal and social history, and premorbid personality.
2. It ensures comprehensive information gathering while allowing flexibility to follow the patient's own narrative.
3. Appearance and behaviour, speech, mood and affect, thought, perception, cognition, and insight.
4. Because the examination directly applies the descriptive psychopathological terms established earlier in the Series.
5. Because certain medical conditions can present with prominent psychiatric symptoms.

**Part 2.5**

1. Neuropsychological, cognitive, behavioural, and personality assessment.

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2. Where diagnostic uncertainty remains after standard assessment, or detailed characterisation of a specific domain is needed.
3. It is more rapid and focused, prioritising immediate safety concerns over comprehensive history taking.
4. Because mental distress commonly presents through physical channels in this specific clinical setting.
5. Emergency interviews are rapid and safety-focused; general practice interviews require sensitivity to subtle somatic cues within a broader medical consultation.

**References and Attributions [Series 2]**


6. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
7. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).
8. World Health Organization (2019). International Classification of Diseases (11th revision).
9. Semple, D., & Smyth, R. (2019). Oxford Handbook of Psychiatry (4th ed.). Oxford University Press.


**Figures, Plates, Tables, and Boxes**

1. Figure 2.1: A diagram comparing the ICD and DSM classification systems and their overlapping diagnostic scope. AI-generated using the prompt: "A single clean, accurate schematic Venn diagram with two overlapping circles labelled ICD and DSM, with a shared central overlapping region, textbook psychiatry classification diagram style, neutral background, no photographic realism, no other panels."
2. Table 2.2: Comparing disorders of perception, thought, and speech. AI-generated using the prompt: "Create a clean clinical reference table titled Comparing Disorders of Perception, Thought, and Speech, listing domain, example finding, and key feature. Medical reference table style with outside border, no photographic elements."
3. Table 2.3: Comparing key disorders of emotion, self, and consciousness. AI-generated using the prompt: "Create a clean clinical reference table titled Comparing Key Disorders of Emotion, Self, and Consciousness, listing term, description, and clinical relevance. Medical reference table style with outside border, no photographic elements."

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4. Figure 2.4: A diagram illustrating the structured components of a comprehensive mental state examination. AI-generated using the prompt: "A single clean, accurate schematic diagram showing seven labelled sequential boxes representing appearance and behaviour, speech, mood and affect, thought, perception, cognition, and insight, connected in a simple vertical sequence, textbook clinical diagram style, neutral background, no photographic realism, no other panels."
5. Figure 2.5: A diagram comparing the interview approach and priorities in emergency, general practice, and specialist psychiatric settings. AI-generated using the prompt: "A single clean, accurate schematic three-panel diagram, one panel labelled Emergency showing a safety focus icon, one labelled General Practice showing a somatic-symptom icon, one labelled Specialist Setting showing a comprehensive assessment icon, textbook clinical diagram style, neutral background, no photographic realism, no other panels."

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**Course code: PSY 601**

**Course title: General Psychiatry**

**Course credit load: 3 Units**

# Series 3: Mood Disorders and Schizophrenia Spectrum Disorders

- **Part 3.1: Unipolar and Bipolar Mood Disorders**
  - Sub Part 3.1.1: Clinical features of depression (unipolar disorder)
  - Sub Part 3.1.2: Clinical features of bipolar disorder
  - Sub Part 3.1.3: Distinguishing unipolar from bipolar disorder
- **Part 3.2: Other Mood Disorders**
  - Sub Part 3.2.1: Dysthymia and cyclothymia
  - Sub Part 3.2.2: Premenstrual dysphoric disorder and atypical depression
  - Sub Part 3.2.3: Seasonal affective disorder
- **Part 3.3: Suicide Risk in Mood Disorders**
  - Sub Part 3.3.1: Epidemiology of suicide risk in mood disorders
  - Sub Part 3.3.2: Suicide risk assessment
  - Sub Part 3.3.3: Management strategy for suicide risk
- **Part 3.4: Psychosis and Schizophrenia**
  - Sub Part 3.4.1: Defining psychosis and its clinical manifestations
  - Sub Part 3.4.2: Epidemiology, clinical course, and prodromal stages of schizophrenia
  - Sub Part 3.4.3: Subtypes and positive, negative, and cognitive symptoms of schizophrenia
- **Part 3.5: Related Psychotic Disorders and Management of Schizophrenia**
  - Sub Part 3.5.1: Delusional disorder and psychotic disorders due to another medical condition
  - Sub Part 3.5.2: Catatonia
  - Sub Part 3.5.3: Management of schizophrenia

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# Introduction

Two genuinely distinct categories of major mental illness dominate this Series, **mood disorders**, spanning depression, bipolar disorder, and a further range of recognised affective presentations, and the **schizophrenia spectrum**, psychiatry's paradigmatic psychotic illness. This Series works through **unipolar and bipolar mood disorders**, **other mood disorders**, the genuinely critical topic of **suicide risk** these conditions carry, **psychosis and schizophrenia** itself, and, finally, **related psychotic disorders and the management of schizophrenia**.

The aim of this Series is to equip you with a thorough understanding of unipolar and bipolar disorders, suicide risk in mood disorders and its assessment and management, psychosis, and the epidemiology, clinical course, subtypes, symptoms, and management of schizophrenia.

This Series begins with **unipolar and bipolar mood disorders**, before turning to **other mood disorders**, **suicide risk in mood disorders**, and **psychosis and schizophrenia**. It concludes with **related psychotic disorders and management of schizophrenia**.

# Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 3.1:** differentiate the clinical features of unipolar and bipolar disorders
- **SLO 3.2:** describe dysthymia, cyclothymia, premenstrual dysphoric disorder, atypical depression, and seasonal affective disorder
- **SLO 3.3:** describe the epidemiology of suicide risk in mood disorders
- **SLO 3.4:** conduct suicide risk assessment and describe management strategy
- **SLO 3.5:** define psychosis and list its clinical manifestations
- **SLO 3.6:** describe the epidemiology, clinical course, and prodromal stages of schizophrenia
- **SLO 3.7:** describe subtypes and positive, negative, and cognitive symptoms of schizophrenia
- **SLO 3.8:** describe delusional disorder and psychotic disorders due to another medical condition
- **SLO 3.9:** describe catatonia, and
- **SLO 3.10:** explain the management of patients with schizophrenia.

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## 3.1 Unipolar and Bipolar Mood Disorders

### 3.1.1 clinical features of depression (unipolar disorder)

***A sustained, pervasive lowering of mood and function***

**Major depressive disorder**, discussed throughout this Part, characteristically presents with a sustained low mood, discussed in relation to mood and affect established in the previous Series of this course, together with anhedonia, reduced capacity to experience pleasure, and a range of further recognised symptoms, including sleep and appetite disturbance, poor concentration, and reduced energy, present for at least two weeks.

This episode of depression, discussed earlier in this sub-Part, is termed **unipolar** given its exclusively depressive, rather than manic or hypomanic, clinical course, distinguishing this presentation from bipolar disorder, discussed further in the next sub-Part, where genuinely both depressive and elevated mood episodes occur across the patient's illness course.

**Fill in the blank:** Major depressive disorder characteristically presents with a sustained low mood, together with anhedonia, reduced capacity to experience _____.

### 3.1.2 clinical features of bipolar disorder

***Alternating episodes of depression and mood elevation***

**Bipolar disorder**, discussed in relation to unipolar depression earlier in this Part, is characterised by the occurrence of at least one **manic** or **hypomanic** episode, elevated or irritable mood together with increased energy, decreased need for sleep, and, in genuinely severe cases, psychotic features, discussed further later in this Series, generally alternating with depressive episodes across the patient's illness course.

The specific distinction between **mania** and **hypomania**, discussed earlier in this sub-Part, lies primarily in severity and functional impact, with mania producing genuinely marked functional impairment, frequently requiring hospitalisation, while hypomania produces a milder, though still clinically significant, degree of mood elevation without this same severe functional disruption.

**Fill in the blank:** Bipolar disorder is characterised by the occurrence of at least one manic or hypomanic episode, generally alternating with depressive episodes across the patient's illness _____.

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## 3.1.3 distinguishing unipolar from bipolar disorder

***A distinction with genuinely direct treatment implications***

Distinguishing unipolar from bipolar disorder, discussed throughout this Part, carries genuinely direct treatment implications, since antidepressant medication alone can, in a patient with underlying bipolar disorder, potentially precipitate a manic episode, meaning careful screening for any past history of mania or hypomania represents an essential component of assessing any patient presenting with depression.

This screening, discussed earlier in this sub-Part, should genuinely be considered in every depressed patient, since bipolar disorder is frequently under-recognised, particularly where a patient's only prior mood elevation episodes were relatively mild, hypomanic rather than fully manic, and therefore never previously brought to clinical attention.

**Fill in the blank:** Careful screening for any past history of mania or hypomania represents an essential component of assessing any patient presenting with _____.

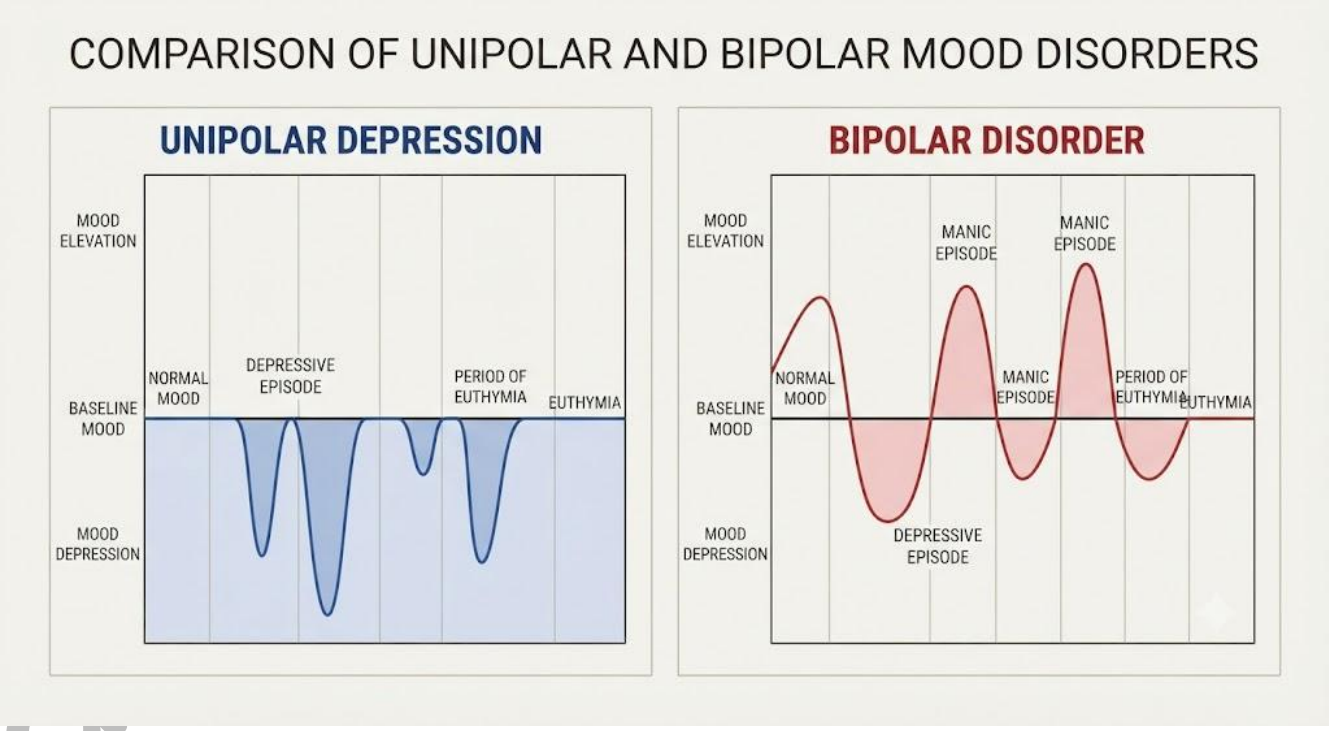


Figure 3.1: A diagram comparing the mood course of unipolar depression and bipolar disorder over time.

**Pilot questions 3.1**

- Describe the clinical features of major depressive disorder. (Linked to SLO 3.1)
- Define bipolar disorder. (Linked to SLO 3.1)
- Distinguish mania from hypomania. (Linked to SLO 3.1)
- Explain why distinguishing unipolar from bipolar disorder carries direct treatment implications. (Linked to SLO 3.1)
- Explain why bipolar disorder is frequently under-recognised. (Linked to SLO 3.1)

## 3.2 Other Mood Disorders

### 3.2.1 dysthymia and cyclothymia

***Chronic, lower-grade variants of depression and bipolar disorder***

**Dysthymia**, discussed in relation to major depressive disorder earlier in this Series, describes a chronic, lower-grade depressive state persisting for at least two years, generally less severe than major depression at any given point but genuinely more persistent, meaning its cumulative impact on functioning can nonetheless be considerable.

**Cyclothymia**, discussed earlier in this sub-Part, represents the analogous chronic, lower-grade variant of bipolar disorder, involving numerous periods of hypomanic and depressive symptoms not meeting full diagnostic criteria for either mania or major depression, again persisting for at least two years, meaning both conditions represent genuinely important, chronic mood presentations distinct from their more acute counterparts.

**Fill in the blank:** Cyclothymia represents the analogous chronic, lower-grade variant of bipolar disorder, involving numerous periods of hypomanic and depressive symptoms not meeting full diagnostic criteria for either mania or major _____.

### 3.2.2 premenstrual dysphoric disorder and atypical depression

***Recognised presentations with a specific temporal or symptom pattern***

**Premenstrual dysphoric disorder**, discussed throughout this Part, describes significant mood disturbance occurring specifically during the luteal phase of the menstrual cycle, resolving with menstrual onset, representing a genuinely important, hormonally linked mood condition distinct from the more sustained mood disorders discussed earlier in this Series.

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**Atypical depression**, discussed earlier in this sub-Part, describes a specific depressive presentation characterised by mood reactivity, genuine improvement in mood in response to positive events, together with increased appetite, increased sleep, and marked sensitivity to interpersonal rejection, a pattern genuinely distinct from the more typical depressive presentation discussed earlier in this Series.

**Fill in the blank:** Premenstrual dysphoric disorder describes significant mood disturbance occurring specifically during the luteal phase of the menstrual cycle, resolving with menstrual _____.

### 3.2.3 seasonal affective disorder

***A depressive pattern following a genuinely predictable seasonal course***

**Seasonal affective disorder**, discussed throughout this Part, describes recurrent depressive episodes following a genuinely predictable seasonal pattern, most commonly occurring during autumn and winter months and remitting during spring and summer, reflecting a recognised relationship between reduced light exposure and mood regulation.

This specific seasonal pattern, discussed earlier in this sub-Part, carries direct treatment relevance, since **light therapy**, in addition to standard depressive treatment approaches, represents a specifically targeted intervention for this particular presentation, meaning accurate recognition of the seasonal pattern genuinely informs treatment selection.

**Fill in the blank:** Seasonal affective disorder describes recurrent depressive episodes following a genuinely predictable seasonal pattern, reflecting a recognised relationship between reduced light exposure and mood _____.

**Table 3.2: Comparing other recognised mood disorders.**

| Disorder | Key temporal or symptom pattern | Notable feature |
|---|---|---|
| Dysthymia | Chronic, lower-grade depression, two years or more | Less severe but more persistent than major depression |
| Cyclothymia | Chronic, lower-grade bipolar pattern, two years or more | Subthreshold hypomanic and depressive periods |
| Seasonal affective disorder | Recurrent, seasonal (autumn/winter) episodes | Responds specifically to light therapy |

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**Pilot questions 3.2**

1. Define dysthymia. (Linked to SLO 3.2)
2. Define cyclothymia. (Linked to SLO 3.2)
3. Describe premenstrual dysphoric disorder. (Linked to SLO 3.2)
4. Describe the characteristic features of atypical depression. (Linked to SLO 3.2)
5. Describe seasonal affective disorder and its specific treatment implication. (Linked to SLO 3.2)

## 3.3 Suicide Risk in Mood Disorders

### 3.3.1 epidemiology of suicide risk in mood disorders

***A genuinely substantial, elevated risk demanding attention***

Mood disorders, discussed throughout this Series, carry substantially elevated suicide risk relative to the general population, with depression and bipolar disorder together representing genuinely leading, well recognised risk factors for both suicide attempt and completed suicide, meaning every patient presenting with a mood disorder warrants careful, routine suicide risk consideration.

This elevated epidemiological risk, discussed earlier in this sub-Part, means suicide risk assessment, discussed further in the next sub-Part, should genuinely represent a routine, standard component of every psychiatric assessment involving a mood disorder, rather than a specialised consideration reserved only for patients displaying obvious, explicit warning signs.

**Fill in the blank:** Mood disorders carry substantially elevated suicide risk relative to the general population, meaning every patient presenting with a mood disorder warrants careful, routine suicide risk _____.

### 3.3.2 suicide risk assessment

***A structured, systematic clinical assessment approach***

**Suicide risk assessment**, discussed throughout this Part, requires systematic enquiry into current suicidal ideation, any specific plan and access to means, prior suicide attempts, and recognised risk factors, including hopelessness, social isolation, and significant recent loss, together building a genuinely comprehensive picture of the patient's own current risk.

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This structured enquiry, discussed earlier in this sub-Part, should genuinely be conducted directly, sensitively, and without hesitation, since asking directly about suicidal thoughts does not genuinely increase risk, contrary to a persistent but genuinely mistaken clinical belief, meaning direct enquiry represents both safe and essential clinical practice.

**Fill in the blank:** Asking directly about suicidal thoughts does not genuinely increase risk, contrary to a persistent but genuinely mistaken clinical _____.

## 3.3.3 management strategy for suicide risk

***A genuinely individualised, safety-focused response***

Management of identified suicide risk, discussed throughout this Part, should genuinely be individualised according to the specific level of risk identified, ranging from outpatient safety planning and increased follow-up frequency for lower risk presentations, to genuinely urgent psychiatric admission, potentially involuntary, discussed in relation to ethical safeguards established in an earlier Series of this course, for genuinely high-risk presentations.

This individualised approach, discussed earlier in this sub-Part, generally includes addressing modifiable risk factors, such as means restriction, discussed in relation to access to lethal means, together with treating the underlying mood disorder itself, meaning effective suicide risk management genuinely addresses both immediate safety and underlying illness together.

**Fill in the blank:** Management of identified suicide risk should genuinely be individualised according to the specific level of risk identified, generally including addressing modifiable risk factors such as means _____.

**Table 3.3: Structured components of suicide risk assessment.**

| Component | What is assessed | Clinical significance |
|---|---|---|
| Ideation and plan | Current suicidal thoughts and any specific plan | Indicates immediacy of risk |
| Access to means | Availability of a means to act on any plan | Directly informs means restriction strategy |
| Risk factors | Hopelessness, isolation, prior attempts, recent loss | Informs overall risk stratification |

**Pilot questions 3.3**

1. Describe the epidemiological relationship between mood disorders and suicide risk. (Linked to SLO 3.3)

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2. List components of a structured suicide risk assessment. (Linked to SLO 3.4)
3. Explain why direct enquiry about suicidal thoughts is considered safe practice. (Linked to SLO 3.4)
4. Describe the range of management responses to identified suicide risk. (Linked to SLO 3.4)
5. Explain the concept of means restriction in suicide risk management. (Linked to SLO 3.4)

## 3.4 Psychosis and Schizophrenia

### 3.4.1 defining psychosis and its clinical manifestations

***A genuine, significant loss of contact with reality***

**Psychosis**, discussed in relation to disorders of perception and thought established in the previous Series of this course, describes a genuine, significant loss of contact with reality, clinically manifesting through hallucinations, delusions, and, frequently, genuinely disorganised thought and behaviour, together representing a syndrome rather than a single specific diagnosis.

This syndrome, discussed earlier in this sub-Part, can result from a range of underlying causes, including primary psychotic disorders such as schizophrenia, discussed further later in this Series, mood disorders with psychotic features, discussed earlier in this Series, and, importantly, underlying medical or substance-related causes, discussed further in a later Series of this course, meaning careful diagnostic evaluation remains essential.

**Fill in the blank:** Psychosis describes a genuine, significant loss of contact with reality, clinically manifesting through hallucinations, delusions, and, frequently, genuinely disorganised thought and _____.

### 3.4.2 epidemiology, clinical course, and prodromal stages of schizophrenia

***A chronic, relapsing illness with a genuinely recognisable early phase***

**Schizophrenia**, discussed throughout this Part, affects approximately one percent of the population worldwide, typically presenting in late adolescence or early adulthood, with a genuinely chronic, relapsing clinical course for most affected patients, though with genuinely considerable variability in overall long-term outcome between individuals.

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The **prodromal phase**, discussed earlier in this sub-Part, describes a period of subtle, non-specific symptoms, including social withdrawal and declining functioning, frequently preceding the first genuine psychotic episode by months or even years, meaning recognising this specific early phase carries genuine potential value for earlier intervention before full psychosis develops.

**Fill in the blank:** The prodromal phase describes a period of subtle, non-specific symptoms, including social withdrawal and declining functioning, frequently preceding the first genuine psychotic episode by months or even _____.

## 3.4.3 subtypes and positive, negative, and cognitive symptoms of schizophrenia

***Three genuinely distinct symptom domains, not a single uniform presentation***

Schizophrenia's clinical presentation, discussed throughout this Part, is genuinely organised into three distinct symptom domains, **positive symptoms**, hallucinations and delusions representing an excess of normal function, **negative symptoms**, including flattened affect and reduced motivation, representing a genuine deficit or absence of normal function, and **cognitive symptoms**, affecting memory, attention, and executive function.

Recognising this genuine three-domain structure, discussed earlier in this sub-Part, carries direct clinical relevance, since these three symptom domains frequently respond quite differently to available treatment, discussed further later in this Series, meaning comprehensive schizophrenia assessment should genuinely characterise all three domains rather than focusing narrowly on positive symptoms alone.

**Fill in the blank:** Schizophrenia's clinical presentation is genuinely organised into positive symptoms, negative symptoms, and cognitive symptoms, three genuinely distinct symptom _____.

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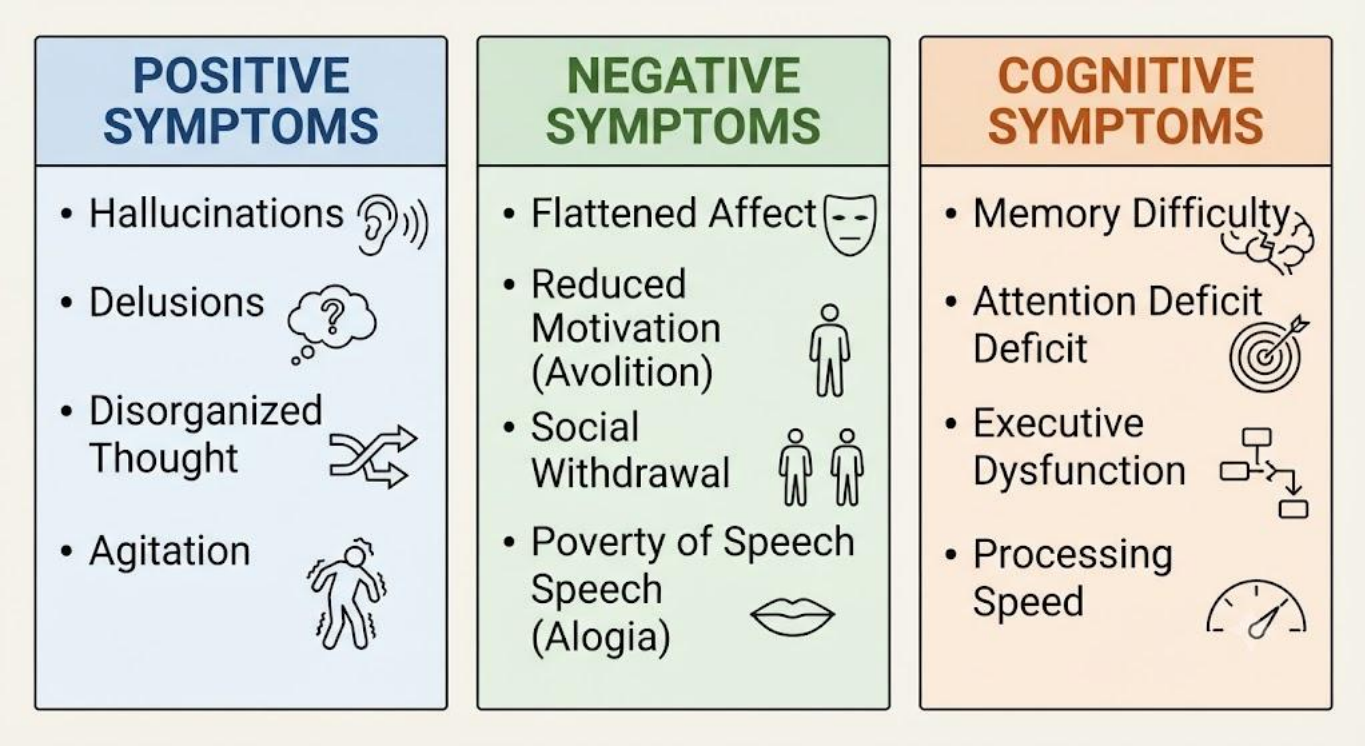


Figure 3.4: A diagram illustrating the three symptom domains of schizophrenia: positive, negative, and cognitive symptoms.

**Pilot questions 3.4**

1. Define psychosis. (Linked to SLO 3.5)
2. List recognised underlying causes of psychosis. (Linked to SLO 3.5)
3. Describe the epidemiology and typical age of onset of schizophrenia. (Linked to SLO 3.6)
4. Define the prodromal phase of schizophrenia. (Linked to SLO 3.6)
5. Distinguish positive, negative, and cognitive symptoms of schizophrenia. (Linked to SLO 3.7)

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## 3.5 Related Psychotic Disorders and Management of Schizophrenia

### 3.5.1 delusional disorder and psychotic disorders due to another medical condition

***Related, though genuinely distinct, psychotic presentations***

**Delusional disorder**, discussed in relation to psychosis established earlier in this Series, describes the presence of one or more genuine, fixed delusions persisting for at least one month, generally without the prominent hallucinations, disorganised speech, or negative symptoms characteristic of schizophrenia, discussed earlier in this Series, representing a genuinely distinct, generally more circumscribed psychotic presentation.

**Psychotic disorders due to another medical condition**, discussed earlier in this sub-Part, require careful identification of a specific, underlying medical cause directly producing the psychotic symptoms, discussed in relation to organic causes of altered consciousness in the previous Series of this course, meaning thorough medical evaluation remains essential before attributing psychosis to a primary psychiatric cause alone.

**Fill in the blank:** Delusional disorder describes the presence of one or more genuine, fixed delusions persisting for at least one month, generally without the prominent hallucinations, disorganised speech, or negative symptoms characteristic of _____.

## 3.5.2 catatonia

***A genuinely distinct motor syndrome, not exclusive to schizophrenia***

**Catatonia**, discussed throughout this Part, describes a genuinely distinct motor syndrome, including immobility, mutism, and posturing, occurring in association with schizophrenia or, importantly, with a range of further psychiatric and medical conditions, meaning catatonia should genuinely be understood as a syndrome that can accompany several distinct underlying conditions rather than a feature exclusive to schizophrenia alone.

Prompt recognition of catatonia, discussed earlier in this sub-Part, carries genuine clinical urgency, since specific, effective treatment is generally available, meaning careful, deliberate screening for catatonic features should genuinely form part of the assessment of any patient presenting with severe psychiatric illness, particularly psychotic or mood disorder presentations.

**Fill in the blank:** Catatonia describes a genuinely distinct motor syndrome, including immobility, mutism, and posturing, occurring in association with schizophrenia or a range of further psychiatric and medical _____.

## 3.5.3 management of schizophrenia

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***A genuinely comprehensive, multimodal treatment approach***

Management of schizophrenia, discussed throughout this Series, generally centres on **antipsychotic medication**, discussed further in a later Series of this course, addressing predominantly positive symptoms, discussed earlier in this Series, together with psychosocial interventions, including family psychoeducation and supported employment, addressing negative and cognitive symptoms and broader functional recovery.

This genuinely comprehensive, multimodal approach, discussed earlier in this sub-Part, reflects the recognition that schizophrenia's genuinely complex, multi-domain symptom presentation, discussed earlier in this Series, requires a correspondingly comprehensive treatment strategy, meaning effective schizophrenia management genuinely extends well beyond pharmacological treatment alone.

**Fill in the blank:** Management of schizophrenia generally centres on antipsychotic medication, together with psychosocial interventions addressing negative and cognitive symptoms and broader functional _____.

**Table 3.5: Comparing schizophrenia, delusional disorder, and catatonia.**

| Condition | Key feature | Clinical relevance |
|---|---|---|
| Schizophrenia | Positive, negative, and cognitive symptoms | Requires comprehensive, multimodal management |
| Delusional disorder | Fixed delusions without prominent other psychotic features | Generally more circumscribed presentation |
| Catatonia | Immobility, mutism, and posturing | Requires prompt recognition given available specific treatment |

**Pilot questions 3.5**

1. Define delusional disorder. (Linked to SLO 3.8)
2. Explain why psychotic disorders due to another medical condition require careful medical evaluation. (Linked to SLO 3.8)
3. Define catatonia. (Linked to SLO 3.9)
4. Explain why prompt recognition of catatonia carries genuine clinical urgency. (Linked to SLO 3.9)
5. Describe the multimodal management approach for schizophrenia. (Linked to SLO 3.10)

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## Series Summary

This Series worked through unipolar and bipolar mood disorders, their clinical features and distinction, other mood disorders, dysthymia, cyclothymia, PMDD, atypical depression, and seasonal affective disorder, suicide risk in mood disorders, its epidemiology, assessment, and management, psychosis and schizophrenia, definition, epidemiology, and symptom domains, and concluded with related psychotic disorders, delusional disorder, catatonia, and the comprehensive management of schizophrenia.

This foundation carries directly into anxiety, obsessive-compulsive, trauma-related, and substance use disorders, examined in the next Series of this course.

## Glossary of Terms

6. **Major depressive disorder:** a sustained low mood with anhedonia and further recognised symptoms, unipolar in course.
7. **Bipolar disorder:** a mood disorder involving at least one manic or hypomanic episode alongside depressive episodes.
8. **Dysthymia:** a chronic, lower-grade depressive state persisting for at least two years.
9. **Cyclothymia:** a chronic, lower-grade bipolar pattern persisting for at least two years.
10. **Seasonal affective disorder:** recurrent depressive episodes following a predictable seasonal pattern.
11. **Suicide risk assessment:** a structured clinical enquiry into suicidal ideation, plan, means, and risk factors.
12. **Means restriction:** a suicide prevention strategy limiting access to lethal means.
13. **Psychosis:** a syndrome of significant loss of contact with reality, manifesting through hallucinations and delusions.
14. **Prodromal phase:** a period of subtle, non-specific symptoms preceding the first psychotic episode of schizophrenia.
15. **Positive symptoms:** schizophrenia symptoms representing an excess of normal function, such as hallucinations and delusions.
16. **Negative symptoms:** schizophrenia symptoms representing a deficit of normal function, such as flattened affect.
17. **Catatonia:** a motor syndrome of immobility, mutism, and posturing, occurring across several conditions.

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## Concept Check Questions [Series 3]

### Objective questions

- Bipolar disorder is characterised by the occurrence of at least one manic or hypomanic episode, generally alternating with depressive episodes across the patient's illness _____.
- Asking directly about suicidal thoughts does not genuinely increase risk, contrary to a persistent but genuinely mistaken clinical _____.
- The prodromal phase describes a period of subtle, non-specific symptoms, including social withdrawal and declining functioning, frequently preceding the first genuine psychotic episode by months or even _____.
- Schizophrenia's clinical presentation is genuinely organised into positive symptoms, negative symptoms, and cognitive symptoms, three genuinely distinct symptom _____.
- Catatonia describes a genuinely distinct motor syndrome occurring in association with schizophrenia or a range of further psychiatric and medical _____.

### Short-answer questions

1. Distinguish mania from hypomania.
2. Define seasonal affective disorder and its specific treatment implication.
3. List components of a structured suicide risk assessment.
4. Distinguish positive, negative, and cognitive symptoms of schizophrenia.
5. Define delusional disorder and catatonia.

### Long-answer questions

6. Discuss the clinical features of unipolar and bipolar disorder and how they are distinguished. (Linked to SLO 3.1)
7. Discuss dysthymia, cyclothymia, PMDD, atypical depression, and seasonal affective disorder. (Linked to SLO 3.2)
8. Discuss suicide risk in mood disorders, its epidemiology, assessment, and management. (Linked to SLO 3.3, SLO 3.4)
9. Discuss psychosis and the epidemiology, clinical course, and symptom domains of schizophrenia. (Linked to SLO 3.5, SLO 3.6, SLO 3.7)
10. Discuss delusional disorder, catatonia, and the management of schizophrenia. (Linked to SLO 3.8, SLO 3.9, SLO 3.10)

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**Answers to Concept Check Questions [Series 3]**

**Objective questions**

11. Course.
12. Belief.
13. Years.
14. Domains.
15. Conditions.

**Short-answer questions**

16. Mania produces marked functional impairment, frequently requiring hospitalisation; hypomania is milder without this severe disruption.
17. Recurrent depressive episodes following a predictable seasonal pattern; treated specifically with light therapy in addition to standard approaches.
18. Enquiry into current ideation, plan and access to means, prior attempts, and recognised risk factors such as hopelessness.
19. Positive symptoms are an excess of function (hallucinations, delusions); negative symptoms are a deficit (flattened affect); cognitive symptoms affect memory and attention.
20. Delusional disorder is fixed delusions without prominent other psychotic features; catatonia is a motor syndrome of immobility, mutism, and posturing.

**Long-answer questions**

21. **Basic response:** Unipolar depression involves sustained low mood alone, while bipolar disorder involves alternating manic/hypomanic and depressive episodes.

**Value-added response:** Distinguishing them carries direct treatment implications, since antidepressants alone can precipitate mania in undiagnosed bipolar disorder.

22. **Basic response:** Dysthymia and cyclothymia represent chronic, lower-grade variants of depression and bipolar disorder respectively.

**Value-added response:** PMDD, atypical depression, and seasonal affective disorder each follow a specific, recognisable temporal or symptom pattern relevant to targeted treatment.

23. **Basic response:** Mood disorders carry substantially elevated suicide risk, requiring routine, structured risk assessment.

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**Value-added response:** Management is individualised by risk level, addressing both immediate safety, including means restriction, and the underlying mood disorder.

24. **Basic response:** Psychosis is a syndrome of reality loss with several possible underlying causes, while schizophrenia is a chronic illness with recognisable epidemiology and course.

**Value-added response:** Its three symptom domains, positive, negative, and cognitive, respond differently to treatment and require comprehensive assessment.

25. **Basic response:** Delusional disorder and catatonia represent related but distinct presentations from full schizophrenia.

**Value-added response:** Comprehensive schizophrenia management combines antipsychotic medication with psychosocial intervention addressing the full range of symptom domains.

**Answers to Pilot Questions [Series 3]**

**Part 3.1**

1. Sustained low mood, anhedonia, and further symptoms including sleep, appetite, concentration, and energy disturbance, for at least two weeks.
2. A mood disorder involving at least one manic or hypomanic episode, generally alternating with depressive episodes.
3. Mania produces marked functional impairment, frequently requiring hospitalisation; hypomania is milder without this severe disruption.
4. Because antidepressants alone can precipitate mania in a patient with underlying, undiagnosed bipolar disorder.
5. Because prior mood elevation episodes may have been mild, hypomanic rather than fully manic, and never previously brought to attention.

**Part 3.2**

6. A chronic, lower-grade depressive state persisting for at least two years.
7. A chronic, lower-grade bipolar pattern persisting for at least two years, with subthreshold hypomanic and depressive periods.
8. Significant mood disturbance during the luteal phase of the menstrual cycle, resolving with menstrual onset.

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9. Mood reactivity, increased appetite, increased sleep, and marked sensitivity to interpersonal rejection.
10. Recurrent depressive episodes following a seasonal pattern; treated specifically with light therapy.

**Part 3.3**

11. Mood disorders carry substantially elevated suicide risk relative to the general population.
12. Current ideation, specific plan and access to means, prior attempts, and recognised risk factors.
13. Because it is a persistent, mistaken belief; direct enquiry is genuinely safe practice.
14. Ranging from outpatient safety planning and increased follow-up to urgent, potentially involuntary admission.
15. Limiting access to lethal means as a modifiable component of overall risk management.

**Part 3.4**

1. A significant loss of contact with reality, manifesting through hallucinations, delusions, and disorganised thought and behaviour.
2. Primary psychotic disorders, mood disorders with psychotic features, and underlying medical or substance-related causes.
3. Approximately one percent of the population worldwide, typically presenting in late adolescence or early adulthood.
4. A period of subtle, non-specific symptoms preceding the first psychotic episode by months or years.
5. Positive symptoms are an excess of function; negative symptoms are a deficit; cognitive symptoms affect memory and attention.

**Part 3.5**

1. Fixed delusions persisting for at least one month, generally without prominent hallucinations or other psychotic features.
2. Because thorough medical evaluation is essential before attributing psychosis to a primary psychiatric cause.
3. A motor syndrome of immobility, mutism, and posturing occurring across several conditions.
4. Because specific, effective treatment is generally available once catatonia is recognised.
5. Antipsychotic medication for positive symptoms, combined with psychosocial intervention for negative and cognitive symptoms and functional recovery.

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**References and Attributions [Series 3]**


6. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
7. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).
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9. Owen, M. J., Sawa, A., & Mortensen, P. B. (2016). Schizophrenia. The Lancet, 388(10039), 86-97.


**Figures, Plates, Tables, and Boxes**

1. Figure 3.1: A diagram comparing the mood course of unipolar depression and bipolar disorder over time. AI-generated using the prompt: "A single clean, accurate schematic line graph diagram with two panels, one labelled Unipolar showing a mood line dipping below a baseline in episodes, the other labelled Bipolar showing a mood line both above and below baseline in alternating episodes, textbook psychiatry diagram style, neutral background, no photographic realism, no other panels."
2. Table 3.2: Comparing other recognised mood disorders. AI-generated using the prompt: "Create a clean clinical reference table titled Comparing Other Recognised Mood Disorders, listing disorder, key temporal or symptom pattern, and notable feature. Medical reference table style with outside border, no photographic elements."
3. Table 3.3: Structured components of suicide risk assessment. AI-generated using the prompt: "Create a clean clinical reference table titled Structured Components of Suicide Risk Assessment, listing component, what is assessed, and clinical significance. Medical reference table style with outside border, no photographic elements."
4. Figure 3.4: A diagram illustrating the three symptom domains of schizophrenia: positive, negative, and cognitive symptoms. AI-generated using the prompt: "A single clean, accurate schematic three-panel diagram, one panel labelled Positive Symptoms listing hallucinations and delusions, one labelled Negative Symptoms listing flattened affect and reduced motivation, one labelled Cognitive Symptoms listing memory and attention difficulty, textbook psychiatry diagram style, neutral background, no photographic realism, no other panels."
5. Table 3.5: Comparing schizophrenia, delusional disorder, and catatonia. AI-generated using the prompt: "Create a clean clinical reference table titled Comparing Schizophrenia, Delusional Disorder, and Catatonia, listing condition, key feature, and clinical relevance. Medical reference table style with outside border, no photographic elements."

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**Course code: PSY 601**

**Course title: General Psychiatry**

**Course credit load: 3 Units**

# Series 4: Anxiety, Obsessive-Compulsive, Trauma-Related, and Substance Use Disorders

- **Part 4.1: Anxiety Disorders**
  - Sub Part 4.1.1: Specific phobia, social phobia, and generalised anxiety disorder
  - Sub Part 4.1.2: Panic disorder and agoraphobia
  - Sub Part 4.1.3: Selective mutism, separation anxiety disorder, and differential diagnosis of anxiety
- **Part 4.2: Obsessive-Compulsive and Related Disorders**
  - Sub Part 4.2.1: Obsessive-compulsive disorder
  - Sub Part 4.2.2: Body dysmorphic disorder and hoarding disorder
  - Sub Part 4.2.3: Trichotillomania, excoriation disorder, and PANDAS
- **Part 4.3: Trauma and Stress-Related Disorders**
  - Sub Part 4.3.1: Posttraumatic stress disorder
  - Sub Part 4.3.2: Acute stress disorder and adjustment disorder
  - Sub Part 4.3.3: Persistent complex bereavement disorder and disinhibited social engagement disorder
- **Part 4.4: Substance Use History and Screening**
  - Sub Part 4.4.1: Principles of empathic, non-judgemental substance use interviewing
  - Sub Part 4.4.2: Established screening instruments
  - Sub Part 4.4.3: Typical presentations of substance use disorders in clinical settings
- **Part 4.5: Intoxication and Withdrawal Across Substance Classes**
  - Sub Part 4.5.1: Alcohol, sedatives/hypnotics, and benzodiazepines
  - Sub Part 4.5.2: Opioids, cannabis, and stimulants
  - Sub Part 4.5.3: Inhalants, barbiturates, caffeine, nicotine, and phencyclidine

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## Introduction

Fear, worry, intrusive thought, and the aftermath of genuine trauma each represent genuinely universal human experiences, yet, when sufficiently severe or persistent, cross a genuine threshold into diagnosable psychiatric illness. This Series works through **anxiety disorders**, **obsessive-compulsive and related disorders**, **trauma and stress-related disorders**, and, turning to a genuinely different clinical domain, the essential skills of **substance use history and screening**, before concluding with the specific clinical features of **intoxication and withdrawal** across the major recognised substance classes.

The aim of this Series is to equip you with a thorough understanding of the differential diagnosis of anxiety, the epidemiology, clinical course, comorbidity, family history, and prognosis of OCD and PTSD, empathic substance use history taking and screening, and the clinical features of intoxication and withdrawal across major substance classes.

This Series begins with **anxiety disorders**, before turning to **obsessive-compulsive and related disorders**, **trauma and stress-related disorders**, and **substance use history and screening**. It concludes with **intoxication and withdrawal across substance classes**.

## Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 4.1:** list differential diagnoses for patients presenting with anxiety, including primary and secondary causes
- **SLO 4.2:** describe specific phobia, social phobia, generalised anxiety disorder, panic disorder, and agoraphobia
- **SLO 4.3:** discuss the epidemiology, clinical course, comorbidity, family history, and prognosis of OCD
- **SLO 4.4:** discuss the epidemiology, clinical course, comorbidity, family history, and prognosis of PTSD
- **SLO 4.5:** describe further obsessive-compulsive and related disorders, and trauma and stress-related disorders
- **SLO 4.6:** explain how to obtain a thorough substance use history using empathic, non-judgemental interviewing techniques
- **SLO 4.7:** describe established substance use screening instruments
- **SLO 4.8:** enumerate typical presentations of substance use disorders in clinical settings

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- **SLO 4.9:** list clinical features of intoxication and withdrawal in alcohol, sedatives, benzodiazepines, opioids, cannabis, and stimulants, and
- **SLO 4.10:** list clinical features of intoxication and withdrawal in inhalants, barbiturates, caffeine, nicotine, and phencyclidine.

## 4.1 Anxiety Disorders

### 4.1.1 specific phobia, social phobia, and generalised anxiety disorder

***Fear focused, socially triggered, and pervasive presentations***

**Specific phobia**, discussed throughout this Part, describes marked, persistent fear of a genuinely specific object or situation, generally leading to active avoidance, while **social phobia** describes marked fear specifically of social or performance situations given concern about negative evaluation by others.

**Generalised anxiety disorder**, discussed earlier in this sub-Part, differs genuinely from both, describing excessive, difficult-to-control worry across multiple life domains rather than any single specific trigger, together with recognised somatic symptoms including muscle tension and restlessness, meaning these three conditions are distinguished primarily by the specificity, or genuine absence of specificity, of the anxiety trigger itself.

**Fill in the blank:** Specific phobia describes marked, persistent fear of a genuinely specific object or situation, generally leading to active _____.

### 4.1.2 panic disorder and agoraphobia

***Discrete attacks and the fear those attacks can genuinely produce***

**Panic disorder**, discussed throughout this Part, describes recurrent, unexpected **panic attacks**, discrete episodes of intense fear accompanied by prominent physical symptoms including palpitations, sweating, and a genuine sense of impending doom, together with persistent concern about further attacks.

**Agoraphobia**, discussed earlier in this sub-Part, frequently co-occurs with panic disorder, describing fear of situations where escape might be genuinely difficult or help unavailable should panic symptoms occur, meaning agoraphobia can be understood as a genuine behavioural response to the fear of experiencing panic in a vulnerable situation.

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**Fill in the blank:** Panic disorder describes recurrent, unexpected panic attacks, discrete episodes of intense fear accompanied by prominent physical symptoms, together with persistent concern about further _____.

## 4.1.3 selective mutism, separation anxiety disorder, and differential diagnosis of anxiety

***Further presentations and the essential question of underlying cause***

**Selective mutism**, discussed throughout this Part, describes consistent failure to speak in specific social situations despite speaking normally elsewhere, while **separation anxiety disorder** describes developmentally excessive fear or anxiety concerning separation from major attachment figures, each recognised as a genuine, distinct anxiety presentation.

**Differential diagnosis** of anxiety, discussed earlier in this sub-Part, requires genuine consideration of both primary anxiety disorders discussed throughout this Part and anxiety secondary to other conditions, including medical illness, substance use, discussed further later in this Series, or another primary psychiatric disorder, meaning thorough evaluation should never assume a primary anxiety diagnosis without genuinely excluding these secondary causes.

**Fill in the blank:** Differential diagnosis of anxiety requires genuine consideration of both primary anxiety disorders and anxiety secondary to other conditions, including medical illness, substance use, or another primary psychiatric _____.

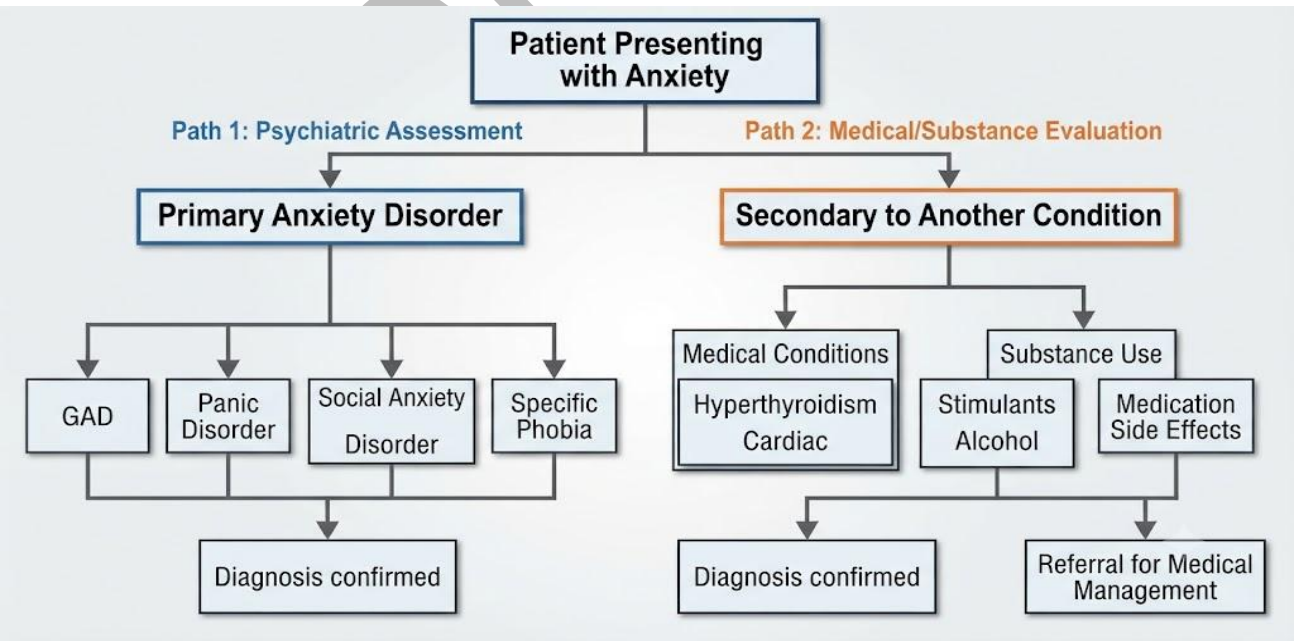


Figure 4.1: A diagram illustrating differential diagnosis pathways for a patient presenting with anxiety, distinguishing primary and secondary causes.

**Pilot questions 4.1**

- Distinguish specific phobia from social phobia. (Linked to SLO 4.2)
- Define generalised anxiety disorder. (Linked to SLO 4.2)
- Describe panic disorder and its characteristic features. (Linked to SLO 4.2)
- Explain the relationship between agoraphobia and panic disorder. (Linked to SLO 4.2)
- List categories of secondary causes to consider in the differential diagnosis of anxiety. (Linked to SLO 4.1)

## 4.2 Obsessive-Compulsive and Related Disorders

### 4.2.1 obsessive-compulsive disorder

***Intrusive thoughts and the compulsions performed to relieve them***

**Obsessive-compulsive disorder**, discussed throughout this Series, involves genuine **obsessions**, intrusive, unwanted thoughts, urges, or images causing significant distress, together with **compulsions**, repetitive behaviours or mental acts performed specifically to reduce the distress the obsession itself produces.

This specific epidemiological and clinical pattern, discussed earlier in this sub-Part, generally shows a chronic, fluctuating course, meaningful comorbidity with mood and anxiety disorders discussed earlier in this Series, and a recognised, though modest, familial genetic contribution, meaning OCD's overall prognosis genuinely benefits from early, appropriately targeted treatment.

**Fill in the blank:** Obsessive-compulsive disorder involves genuine obsessions, together with compulsions, repetitive behaviours or mental acts performed specifically to reduce the distress the obsession itself _____.

### 4.2.2 body dysmorphic disorder and hoarding disorder

***Related conditions sharing OCD's core obsessive-compulsive pattern***

**Body dysmorphic disorder**, discussed throughout this Part, involves preoccupation with perceived defects in physical appearance that are genuinely not observable or appear only slight to others, together with repetitive behaviours, such as mirror checking, performed in response to this specific appearance-related concern.

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**Hoarding disorder**, discussed earlier in this sub-Part, involves persistent difficulty discarding possessions regardless of their actual value, leading to genuinely significant clutter that compromises normal use of living spaces, together sharing with body dysmorphic disorder the same underlying obsessive-compulsive pattern discussed earlier in this Series, despite their genuinely different specific content.

**Fill in the blank:** Hoarding disorder involves persistent difficulty discarding possessions regardless of their actual value, leading to genuinely significant clutter that compromises normal use of living _____.

## 4.2.3 trichotillomania, excoriation disorder, and pandas

***Body-focused repetitive behaviours and a genuine paediatric variant***

**Trichotillomania**, discussed throughout this Part, describes recurrent hair pulling resulting in genuine hair loss, while **excoriation disorder** describes recurrent skin picking resulting in genuine skin lesions, each representing a recognised, distinct body-focused repetitive behaviour disorder within the broader obsessive-compulsive spectrum discussed throughout this Series.

**PANDAS**, discussed earlier in this sub-Part, describes paediatric autoimmune neuropsychiatric disorders associated with streptococcal infection, a genuinely distinct clinical entity involving sudden-onset obsessive-compulsive symptoms in children temporally linked to streptococcal infection, meaning this specific presentation carries genuinely important, distinct diagnostic and treatment implications.

**Fill in the blank:** PANDAS describes paediatric autoimmune neuropsychiatric disorders associated with streptococcal infection, involving sudden-onset obsessive-compulsive symptoms in children temporally linked to streptococcal _____.

**Table 4.2: Comparing obsessive-compulsive and related disorders.**

| Disorder | Core feature | Notable distinguishing point |
|---|---|---|
| OCD | Obsessions relieved by compulsions | Chronic course with meaningful comorbidity |
| Body dysmorphic disorder | Preoccupation with perceived appearance defects | Defects not observable or only slight to others |
| Trichotillomania | Recurrent hair pulling causing hair loss | A body-focused repetitive behaviour disorder |

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**Pilot questions 4.2**

1. Define obsession and compulsion. (Linked to SLO 4.3)
2. Describe the epidemiology and clinical course of OCD. (Linked to SLO 4.3)
3. Define body dysmorphic disorder. (Linked to SLO 4.5)
4. Define hoarding disorder. (Linked to SLO 4.5)
5. Describe PANDAS and its distinguishing clinical features. (Linked to SLO 4.5)

## 4.3 Trauma and Stress-Related Disorders

### 4.3.1 posttraumatic stress disorder

***A recognised response to genuinely traumatic experience***

**Posttraumatic stress disorder**, discussed throughout this Series, develops following exposure to a genuinely traumatic event, characterised by intrusive re-experiencing, avoidance of trauma reminders, negative alterations in mood and cognition, and hyperarousal, together persisting for at least one month following the traumatic exposure itself.

PTSD's specific epidemiology and clinical course, discussed earlier in this sub-Part, show genuinely meaningful comorbidity with depression and substance use disorders, discussed further later in this Series, together with a recognised familial contribution to individual vulnerability, meaning prognosis genuinely varies considerably depending on trauma severity, ongoing support, and timely treatment access.

**Fill in the blank:** Posttraumatic stress disorder develops following exposure to a genuinely traumatic event, characterised by intrusive re-experiencing, avoidance of trauma reminders, negative alterations in mood and cognition, and _____.

### 4.3.2 acute stress disorder and adjustment disorder

***Related presentations distinguished by timing and trigger severity***

**Acute stress disorder**, discussed throughout this Part, describes a similar symptom pattern to PTSD, discussed earlier in this Series, occurring within the first month following trauma exposure, representing a genuinely distinct diagnostic category based specifically on this earlier timeframe rather than any fundamentally different underlying symptom pattern.

**Adjustment disorder**, discussed earlier in this sub-Part, describes an emotional or behavioural response to a genuinely identifiable stressor that is disproportionate to what would ordinarily be

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expected, occurring without meeting full criteria for PTSD or acute stress disorder, meaning adjustment disorder generally reflects a somewhat milder, though still clinically significant, stress-related presentation.

**Fill in the blank:** Acute stress disorder describes a similar symptom pattern to PTSD, occurring within the first month following trauma exposure, representing a genuinely distinct diagnostic category based specifically on this earlier _____.

## 4.3.3 persistent complex bereavement disorder and disinhibited social engagement disorder

***Grief and early attachment disruption as distinct trauma-related presentations***

**Persistent complex bereavement disorder**, discussed throughout this Part, describes genuinely prolonged, impairing grief persisting well beyond what would ordinarily be expected following bereavement, involving persistent yearning, difficulty accepting the death, and significant functional impairment continuing for at least twelve months in adults.

**Disinhibited social engagement disorder**, discussed earlier in this sub-Part, describes a pattern of genuinely inappropriate familiarity with unfamiliar adults, developing in children with a history of significant early social neglect or disrupted attachment, meaning this specific condition reflects the genuinely lasting developmental impact of early caregiving disruption discussed further in relation to childhood attachment in related coursework.

**Fill in the blank:** Disinhibited social engagement disorder describes a pattern of genuinely inappropriate familiarity with unfamiliar adults, developing in children with a history of significant early social neglect or disrupted _____.

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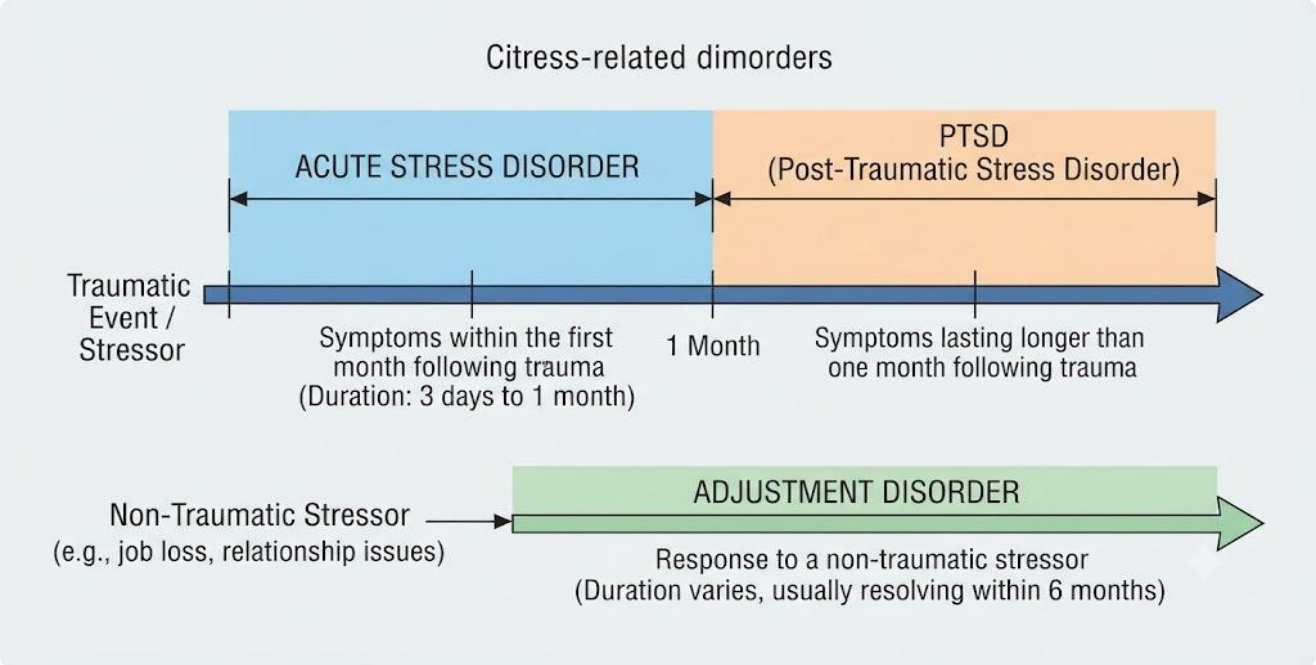


Figure 4.3: A diagram illustrating the timeline distinguishing acute stress disorder, PTSD, and adjustment disorder following a traumatic or stressful event.

Pilot questions 4.3

1. Describe the diagnostic features of PTSD. (Linked to SLO 4.4)
2. Describe the epidemiology and comorbidity of PTSD. (Linked to SLO 4.4)
3. Distinguish acute stress disorder from PTSD. (Linked to SLO 4.5)
4. Define adjustment disorder. (Linked to SLO 4.5)
5. Describe persistent complex bereavement disorder and disinhibited social engagement disorder. (Linked to SLO 4.5)

## 4.4 Substance Use History and Screening

### 4.4.1 principles of empathic, non-judgemental substance use interviewing

***An approach genuinely necessary given the stigma this topic carries***

**Empathic, non-judgemental interviewing**, discussed throughout this Part, represents an essential principle when obtaining a substance use history, since substance use carries genuine, considerable social stigma that can lead patients to minimise or conceal their actual use if the clinician's own approach feels judgemental or confrontational.

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This specific interviewing approach, discussed earlier in this sub-Part, generally uses open-ended questions, genuine reflective listening, and a deliberately normalised framing acknowledging that substance use exists across a genuine spectrum, meaning skilled, empathic interviewing technique directly supports obtaining a more genuinely accurate, complete substance use history.

**Fill in the blank:** Empathic, non-judgemental interviewing is essential when obtaining a substance use history, since substance use carries genuine, considerable social _____.

## 4.4.2 established screening instruments

***Standardised, validated tools supporting consistent detection***

**Established screening instruments**, discussed throughout this Part, including standardised, validated questionnaires assessing alcohol and other substance use, provide a structured, consistent complement to open clinical interview, supporting reliable identification of substance use disorders that might otherwise be genuinely missed.

These specific instruments, discussed earlier in this sub-Part, generally screen for both quantity and frequency of use and the genuine functional or social consequences that use has produced, meaning a genuinely complete substance use assessment combines both structured screening instruments and the empathic interview technique discussed earlier in this Part.

**Fill in the blank:** Established screening instruments generally screen for both quantity and frequency of use and the genuine functional or social _____ that use has produced.

## 4.4.3 typical presentations of substance use disorders in clinical settings

***Recognising substance use behind non-obvious clinical presentations***

Substance use disorders, discussed throughout this Series, frequently present in genuinely non-obvious ways within general medical and psychiatric clinical settings, including unexplained trauma, recurrent infections, unexplained mood or anxiety symptoms, or erratic attendance patterns, rather than a patient presenting explicitly seeking help for substance use itself.

Recognising these specific typical presentations, discussed earlier in this sub-Part, requires genuine, maintained clinical suspicion, meaning routine substance use screening, discussed earlier in this Part, should genuinely form part of standard clinical assessment across essentially every clinical setting, rather than being reserved only for patients displaying obvious, explicit signs of substance use.

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**Fill in the blank:** Substance use disorders frequently present in genuinely non-obvious ways within general medical and psychiatric clinical settings, requiring genuine, maintained clinical _____.

**Table 4.4: Principles of effective substance use assessment.**

| Component | Approach | Purpose |
|---|---|---|
| Empathic interviewing | Open-ended, non-judgemental questioning | Reduces minimisation or concealment of use |
| Screening instruments | Standardised, validated questionnaires | Supports consistent, reliable detection |
| Clinical suspicion | Routine screening across all settings | Identifies non-obvious presentations |

**Pilot questions 4.4**

1. Explain why empathic, non-judgemental interviewing is essential when taking a substance use history. (Linked to SLO 4.6)
2. Describe the general approach used in empathic substance use interviewing. (Linked to SLO 4.6)
3. Describe what established substance use screening instruments generally assess. (Linked to SLO 4.7)
4. List examples of typical, non-obvious presentations of substance use disorders. (Linked to SLO 4.8)
5. Explain why routine substance use screening should apply across all clinical settings. (Linked to SLO 4.8)

## 4.5 Intoxication and Withdrawal Across Substance Classes

### 4.5.1 alcohol, sedatives/hypnotics, and benzodiazepines

***A genuinely dangerous withdrawal pattern shared across this class***

**Alcohol intoxication**, discussed throughout this Part, presents with slurred speech, incoordination, and disinhibition, while **alcohol withdrawal** can progress to genuinely dangerous tremor, seizures, and, in severe cases, delirium tremens, a genuine medical emergency requiring prompt recognition and treatment.

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**Sedative, hypnotic, and benzodiazepine** intoxication and withdrawal, discussed earlier in this sub-Part, follow a genuinely similar pattern given these substances' shared mechanism of action, meaning withdrawal from any substance within this broader class carries comparable, genuine seizure risk requiring similarly careful clinical management.

**Fill in the blank:** Alcohol withdrawal can progress to genuinely dangerous tremor, seizures, and, in severe cases, delirium tremens, a genuine medical _____ requiring prompt recognition and treatment.

## 4.5.2 opioids, cannabis, and stimulants

***Genuinely contrasting intoxication and withdrawal patterns***

**Opioid intoxication**, discussed throughout this Part, presents with pupillary constriction, sedation, and, in genuine overdose, respiratory depression, while **opioid withdrawal**, though generally not life-threatening, produces genuinely significant distress, including muscle aches, diarrhoea, and pronounced drug craving.

**Cannabis** intoxication, discussed earlier in this sub-Part, produces euphoria, altered perception, and increased appetite, while **stimulant** intoxication, including cocaine and amphetamines, produces genuine sympathetic activation, elevated mood, and increased energy, with corresponding withdrawal generally producing a genuine, though not life-threatening, dysphoric crash phase.

**Fill in the blank:** Opioid intoxication presents with pupillary constriction, sedation, and, in genuine overdose, respiratory _____.

## 4.5.3 inhalants, barbiturates, caffeine, nicotine, and phencyclidine

***A further range of substances with genuinely distinct clinical patterns***

**Inhalant** intoxication, discussed throughout this Part, produces euphoria and disinhibition alongside genuine risk of sudden cardiac toxicity, while **barbiturate** intoxication and withdrawal parallel the sedative-hypnotic pattern discussed earlier in this Series, carrying similarly genuine seizure risk during withdrawal.

**Caffeine** and **nicotine**, discussed earlier in this sub-Part, produce genuinely milder, though clinically recognised, intoxication and withdrawal syndromes, while **phencyclidine** intoxication produces a genuinely distinct pattern, including dissociation, nystagmus, and, in severe cases, significant agitation or violence, meaning each specific substance within this final group carries a genuinely distinct, recognisable clinical signature.

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**Fill in the blank:** Phencyclidine intoxication produces a genuinely distinct pattern, including dissociation, nystagmus, and, in severe cases, significant agitation or _____.

**Table 4.5: Comparing intoxication features across selected substance classes.**

| Substance class | Key intoxication feature | Withdrawal risk |
|---|---|---|
| Alcohol/sedative-hypnotic/benzodiazepine | Slurred speech, incoordination, disinhibition | Genuinely dangerous, including seizure risk |
| Opioid | Pupillary constriction, sedation | Significant distress, not generally life-threatening |
| Phencyclidine | Dissociation, nystagmus, agitation | Less classically defined withdrawal syndrome |

**Pilot questions 4.5**

1. Describe the clinical features of alcohol intoxication and withdrawal. (Linked to SLO 4.9)
2. Explain why benzodiazepine withdrawal carries similar risk to alcohol withdrawal. (Linked to SLO 4.9)
3. Describe the clinical features of opioid intoxication and withdrawal. (Linked to SLO 4.9)
4. Describe the clinical features of stimulant intoxication. (Linked to SLO 4.9)
5. Describe the clinical features of phencyclidine intoxication. (Linked to SLO 4.10)

**Series Summary**

This Series set out to build a thorough, practical understanding of anxiety and related disorders, trauma and stress-related presentations, and substance use assessment across every major recognised substance class, and each Part has now contributed a distinct piece of that picture. Part 4.1 worked through the specific anxiety disorders and the essential principle of ruling out secondary causes before settling on a primary diagnosis, while Part 4.2 turned to OCD and the wider obsessive-compulsive spectrum, from body dysmorphic disorder through to the genuinely distinct paediatric presentation of PANDAS. Part 4.3 then examined trauma and stress-related disorders, distinguishing PTSD from acute stress disorder largely by timing, and Part 4.4 shifted focus toward the practical, interpersonal skills of empathic substance use history taking and screening. Part 4.5 closed the Series with the specific intoxication and withdrawal features across alcohol, sedatives, opioids, stimulants, and several further substance classes.

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Taken together, you should now be genuinely able to list differential diagnoses for anxiety, discuss the epidemiology and course of OCD and PTSD, obtain a substance use history using empathic technique and established screening tools, and recognise the clinical features of intoxication and withdrawal across the major substance classes, directly fulfilling every Series Learning Outcome set out at the start of this Series. This foundation carries directly into personality disorders and clinical psychopharmacology, examined in the final Series of this course.

**Glossary of Terms**

6. **Acute stress disorder:** a PTSD-like symptom pattern occurring within the first month following trauma exposure.
7. **Adjustment disorder:** a disproportionate emotional or behavioural response to an identifiable stressor.
8. **Agoraphobia:** fear of situations where escape might be difficult or help unavailable, often linked to panic disorder.
9. **Body dysmorphic disorder:** preoccupation with perceived appearance defects that are not observable or only slight to others.
10. **Compulsion:** a repetitive behaviour or mental act performed to reduce distress from an obsession.
11. **Delirium tremens:** a severe, potentially life-threatening complication of alcohol withdrawal.
12. **Empathic interviewing:** a non-judgemental, open-ended approach to sensitive history taking, such as substance use.
13. **Generalised anxiety disorder:** excessive, difficult-to-control worry across multiple life domains without a single specific trigger.
14. **Hoarding disorder:** persistent difficulty discarding possessions, leading to significant clutter compromising living spaces.
15. **Obsession:** an intrusive, unwanted thought, urge, or image causing significant distress.
16. **PANDAS:** paediatric autoimmune neuropsychiatric disorders associated with streptococcal infection.
17. **Panic attack:** a discrete episode of intense fear accompanied by prominent physical symptoms.
18. **Persistent complex bereavement disorder:** prolonged, impairing grief persisting well beyond what would ordinarily be expected.
19. **Phencyclidine:** a substance producing a distinct intoxication pattern including dissociation and nystagmus.
20. **Posttraumatic stress disorder:** a disorder developing after traumatic exposure, involving re-experiencing, avoidance, and hyperarousal.

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21. **Screening instrument:** a standardised, validated tool used to detect substance use or another condition.
22. **Trichotillomania:** recurrent hair pulling resulting in hair loss.

## Concept Check Questions [Series 4]

### Objective questions

- Specific phobia describes marked, persistent fear of a genuinely specific object or situation, generally leading to active _____.
- Obsessive-compulsive disorder involves genuine obsessions, together with compulsions, repetitive behaviours or mental acts performed specifically to reduce the distress the obsession itself _____.
- Posttraumatic stress disorder develops following exposure to a genuinely traumatic event, characterised by intrusive re-experiencing, avoidance of trauma reminders, negative alterations in mood and cognition, and _____.
- Empathic, non-judgemental interviewing is essential when obtaining a substance use history, since substance use carries genuine, considerable social _____.
- Alcohol withdrawal can progress to genuinely dangerous tremor, seizures, and, in severe cases, delirium tremens, a genuine medical _____ requiring prompt recognition and treatment.

### Short-answer questions

1. Distinguish specific phobia from social phobia.
2. Define body dysmorphic disorder and hoarding disorder.
3. Distinguish acute stress disorder from PTSD.
4. Describe the general approach used in empathic substance use interviewing.
5. Describe the clinical features of opioid intoxication and withdrawal.

### Long-answer questions

6. Discuss the specific anxiety disorders and the approach to differential diagnosis of anxiety. (Linked to SLO 4.1, SLO 4.2)
7. Discuss the epidemiology, clinical course, comorbidity, family history, and prognosis of OCD, and further obsessive-compulsive spectrum disorders. (Linked to SLO 4.3, SLO 4.5)
8. Discuss the epidemiology, clinical course, comorbidity, family history, and prognosis of PTSD, and related trauma and stress disorders. (Linked to SLO 4.4, SLO 4.5)

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9. Discuss empathic substance use interviewing, screening instruments, and typical clinical presentations of substance use disorders. (Linked to SLO 4.6, SLO 4.7, SLO 4.8)
10. Discuss the clinical features of intoxication and withdrawal across major substance classes. (Linked to SLO 4.9, SLO 4.10)

**Answers to Concept Check Questions [Series 4]**

**Objective questions**

11. Avoidance.
12. Produces.
13. Hyperarousal.
14. Stigma.
15. Emergency.

**Short-answer questions**

16. Specific phobia involves fear of a specific object or situation; social phobia involves fear of social or performance situations given concern about negative evaluation.
17. Body dysmorphic disorder is preoccupation with perceived, largely unobservable appearance defects; hoarding disorder is persistent difficulty discarding possessions causing significant clutter.
18. Acute stress disorder occurs within the first month following trauma; PTSD is diagnosed once symptoms persist beyond one month.
19. Open-ended questioning, genuine reflective listening, and a deliberately normalised, non-judgemental framing.
20. Intoxication presents with pupillary constriction, sedation, and, in overdose, respiratory depression; withdrawal produces significant distress including muscle aches and craving.

**Long-answer questions**

21. **Basic response:** Anxiety disorders include specific phobia, social phobia, GAD, panic disorder, and agoraphobia, each distinguished by trigger specificity.

**Value-added response:** Differential diagnosis must genuinely exclude secondary causes, including medical illness and substance use, before confirming a primary anxiety diagnosis.

22. **Basic response:** OCD shows a chronic, fluctuating course with meaningful comorbidity and modest familial contribution.

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**Value-added response:** Related spectrum disorders, including body dysmorphic disorder, hoarding disorder, and PANDAS, share the same core obsessive-compulsive pattern with genuinely distinct specific content.

23. **Basic response:** PTSD develops following traumatic exposure, with meaningful comorbidity and variable prognosis depending on severity and support.

**Value-added response:** Acute stress disorder, adjustment disorder, and persistent complex bereavement disorder each represent related but genuinely distinct trauma or stress-related presentations.

24. **Basic response:** Empathic interviewing reduces minimisation given the stigma surrounding substance use, complemented by standardised screening instruments.

**Value-added response:** Recognising non-obvious clinical presentations requires maintained suspicion and routine screening across every clinical setting.

25. **Basic response:** Alcohol, sedatives, and benzodiazepines share a genuinely dangerous withdrawal pattern, while opioids, cannabis, and stimulants show contrasting intoxication profiles.

**Value-added response:** Inhalants, barbiturates, caffeine, nicotine, and phencyclidine each carry a genuinely distinct, recognisable clinical signature requiring specific recognition.

**Answers to Pilot Questions [Series 4]**

**Part 4.1**

1. Specific phobia involves fear of a specific object or situation; social phobia involves fear of social or performance situations.
2. Excessive, difficult-to-control worry across multiple life domains, together with somatic symptoms such as muscle tension.
3. Recurrent, unexpected discrete episodes of intense fear with prominent physical symptoms and persistent concern about further attacks.
4. Agoraphobia can be understood as a behavioural response to the fear of experiencing panic in a vulnerable situation.
5. Medical illness, substance use, and another primary psychiatric disorder.

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**Part 4.2**

6. An obsession is an intrusive, unwanted thought or urge; a compulsion is a repetitive behaviour performed to reduce the resulting distress.
7. A chronic, fluctuating course with meaningful comorbidity with mood and anxiety disorders and a modest familial contribution.
8. Preoccupation with perceived appearance defects that are not observable or appear only slight to others.
9. Persistent difficulty discarding possessions regardless of value, leading to significant clutter compromising living spaces.
10. Sudden-onset obsessive-compulsive symptoms in children temporally linked to streptococcal infection.

**Part 4.3**

11. Intrusive re-experiencing, avoidance of trauma reminders, negative alterations in mood and cognition, and hyperarousal.
12. Meaningful comorbidity with depression and substance use disorders, and a recognised familial contribution to vulnerability.
13. Acute stress disorder occurs within the first month following trauma; PTSD is diagnosed once symptoms persist beyond that period.
14. A disproportionate emotional or behavioural response to an identifiable stressor, without meeting full PTSD or acute stress disorder criteria.
15. Persistent complex bereavement disorder is prolonged, impairing grief; disinhibited social engagement disorder is inappropriate familiarity with unfamiliar adults following early neglect.

**Part 4.4**

1. Because substance use carries significant social stigma that can lead patients to minimise or conceal their actual use.
2. Open-ended questions, genuine reflective listening, and a deliberately normalised framing.
3. Quantity and frequency of use, and the functional or social consequences that use has produced.
4. Unexplained trauma, recurrent infections, unexplained mood or anxiety symptoms, and erratic attendance patterns.
5. Because substance use disorders frequently present in non-obvious ways requiring maintained clinical suspicion everywhere.

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**Part 4.5**

1. Intoxication presents with slurred speech, incoordination, and disinhibition; withdrawal can progress to tremor, seizures, and delirium tremens.
2. Because benzodiazepines share a similar mechanism of action with alcohol, carrying comparable seizure risk during withdrawal.
3. Intoxication presents with pupillary constriction, sedation, and respiratory depression in overdose; withdrawal produces distress including muscle aches and craving.
4. Sympathetic activation, elevated mood, and increased energy.
5. Dissociation, nystagmus, and, in severe cases, significant agitation or violence.

**References and Attributions [Series 4]**


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**Figures, Plates, Tables, and Boxes**

1. Figure 4.1: A diagram illustrating differential diagnosis pathways for a patient presenting with anxiety, distinguishing primary and secondary causes. AI-generated using the prompt: "A single clean, accurate schematic decision-tree diagram starting with a box labelled Patient Presenting with Anxiety, branching into two labelled paths, Primary Anxiety Disorder and Secondary to Another Condition, textbook clinical diagram style, neutral background, no photographic realism, no other panels."
2. Table 4.2: Comparing obsessive-compulsive and related disorders. AI-generated using the prompt: "Create a clean clinical reference table titled Comparing Obsessive-Compulsive and Related Disorders, listing disorder, core feature, and notable

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distinguishing point. Medical reference table style with outside border, no photographic elements."

3. Figure 4.3: A diagram illustrating the timeline distinguishing acute stress disorder, PTSD, and adjustment disorder following a traumatic or stressful event. AI-generated using the prompt: "A single clean, accurate schematic horizontal timeline diagram with three labelled segments, Acute Stress Disorder within the first month, PTSD beyond one month, and Adjustment Disorder following a non-traumatic stressor, textbook clinical diagram style, neutral background, no photographic realism, no other panels."
4. Table 4.4: Principles of effective substance use assessment. AI-generated using the prompt: "Create a clean clinical reference table titled Principles of Effective Substance Use Assessment, listing component, approach, and purpose. Medical reference table style with outside border, no photographic elements."
5. Table 4.5: Comparing intoxication features across selected substance classes. AI-generated using the prompt: "Create a clean clinical reference table titled Comparing Intoxication Features Across Selected Substance Classes, listing substance class, key intoxication feature, and withdrawal risk. Medical reference table style with outside border, no photographic elements."

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**Course code: PSY 601**

**Course title: General Psychiatry**

**Course credit load: 3 Units**

# Series 5: Personality Disorders and Clinical Psychopharmacology

- **Part 5.1: Concepts of Personality and Personality Disorders**
  - Sub Part 5.1.1: Personality traits versus personality disorder
  - Sub Part 5.1.2: The relevance of personality disorders in providing care
  - Sub Part 5.1.3: Personality change due to another medical condition
- **Part 5.2: Cluster A and Cluster B Personality Disorders**
  - Sub Part 5.2.1: Cluster A personality disorders
  - Sub Part 5.2.2: Cluster B personality disorders: antisocial and borderline
  - Sub Part 5.2.3: Cluster B personality disorders: histrionic and narcissistic
- **Part 5.3: Cluster C Personality Disorders and Rational Prescribing**
  - Sub Part 5.3.1: Cluster C personality disorders
  - Sub Part 5.3.2: Principles of rational prescribing in psychiatry
  - Sub Part 5.3.3: Adverse drug reactions in psychopharmacology
- **Part 5.4: Major Psychotropic Drug Classes**
  - Sub Part 5.4.1: Antipsychotics and mood stabilisers
  - Sub Part 5.4.2: Antidepressants and anxiolytics
  - Sub Part 5.4.3: Anticonvulsants, cognitive enhancers, and drugs for dementia
- **Part 5.5: Implementing and Monitoring Psychotropic Pharmacotherapy**
  - Sub Part 5.5.1: Stimulants, hypnotics, and drugs used in substance dependence
  - Sub Part 5.5.2: Prescribing in pregnancy
  - Sub Part 5.5.3: Implementing, monitoring, and discontinuing psychotropic pharmacotherapy

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# Introduction

This final Series closes the course with two genuinely distinct, though equally essential, domains, **personality disorders**, patterns of enduring, pervasive difficulty that shape how a person relates to the world across essentially every context, and **clinical psychopharmacology**, the practical, evidence-based drug treatment underlying much of modern psychiatric care. This Series works through **concepts of personality and personality disorders**, the **cluster A and B**, and, in turn, **cluster C personality disorders**, before turning to **rational prescribing**, the **major psychotropic drug classes**, and, finally, **implementing and monitoring psychotropic pharmacotherapy**.

The aim of this Series is to equip you with a thorough understanding of the concepts and relevance of personality traits and disorders, the three-cluster conceptualisation of personality disorders, common psychotropic medications, and the factors relevant to implementing, monitoring, and discontinuing psychotropic pharmacotherapy.

This Series begins with **concepts of personality and personality disorders**, before turning to **cluster A and cluster B personality disorders**, **cluster C personality disorders and rational prescribing**, and **major psychotropic drug classes**. It concludes with **implementing and monitoring psychotropic pharmacotherapy**.

# Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 5.1:** discuss the concepts and relevance of personality traits and disorders in providing care
- **SLO 5.2:** list the three-cluster conceptualisation of personality disorders and describe typical features of cluster A and cluster B disorders
- **SLO 5.3:** describe typical features of cluster C personality disorders
- **SLO 5.4:** describe the principles of rational prescribing and adverse drug reactions in psychopharmacology
- **SLO 5.5:** discuss antipsychotics and mood stabilisers with regard to indications, mechanism of action, and adverse effects
- **SLO 5.6:** discuss antidepressants and anxiolytics with regard to indications, mechanism of action, and adverse effects
- **SLO 5.7:** discuss anticonvulsants, cognitive enhancers, and drugs for dementia
- **SLO 5.8:** discuss stimulants, hypnotics, and drugs used in substance dependence

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- **SLO 5.9:** describe factors relevant to prescribing psychotropic medication in pregnancy, and
- **SLO 5.10:** enumerate factors relevant to implementing, monitoring, and discontinuing psychotropic pharmacotherapy.

## 5.1 Concepts of Personality and Personality Disorders

### 5.1.1 personality traits versus personality disorder

***A genuine matter of degree, rigidity, and functional impact***

**Personality traits**, discussed throughout this Part, describe genuinely enduring patterns of thinking, feeling, and behaving present in every individual, becoming a **personality disorder** only when these traits are genuinely inflexible, pervasive across essentially every life context, and cause significant distress or functional impairment.

This distinction, discussed earlier in this sub-Part, means personality disorder should genuinely be understood as an extreme, maladaptive, functionally impairing variant of otherwise normal personality variation, rather than a genuinely separate, categorically distinct phenomenon, meaning careful clinical judgement remains essential in distinguishing genuine disorder from simply a strong, though functional, personality style.

**Fill in the blank:** A personality disorder occurs when personality traits are genuinely inflexible, pervasive across essentially every life context, and cause significant distress or functional _____.

### 5.1.2 the relevance of personality disorders in providing care

***A genuine, direct influence on the therapeutic relationship itself***

Personality disorders, discussed throughout this Part, carry genuine direct relevance to clinical care beyond their own specific diagnostic criteria, since they meaningfully shape how a patient engages with treatment, relates to the clinician, and responds to the broader healthcare system, frequently complicating management of any coexisting psychiatric or medical condition.

Recognising this genuine influence, discussed earlier in this sub-Part, allows the clinician to adapt their own therapeutic approach appropriately, meaning genuine awareness of personality disorder represents an essential component of comprehensive care rather than a narrow, purely

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diagnostic consideration relevant only when personality disorder is itself the primary presenting concern.

**Fill in the blank:** Personality disorders meaningfully shape how a patient engages with treatment, relates to the clinician, and responds to the broader healthcare _____.

### 5.1.3 personality change due to another medical condition

***When a genuine change in character reflects an organic cause***

**Personality change due to another medical condition**, discussed throughout this Part, describes a genuine, persistent alteration in personality directly attributable to the physiological effects of an identifiable medical condition, such as traumatic brain injury or a structural brain lesion, distinguishing this specific presentation from the developmental, lifelong personality disorders discussed further later in this Series.

This important distinction, discussed earlier in this sub-Part, carries genuine diagnostic significance, since a sudden, genuinely new personality change in adulthood, particularly without a corresponding developmental history, should always prompt careful consideration of an underlying medical cause rather than immediate assumption of a primary personality disorder.

**Fill in the blank:** Personality change due to another medical condition describes a genuine, persistent alteration in personality directly attributable to the physiological effects of an identifiable medical _____.

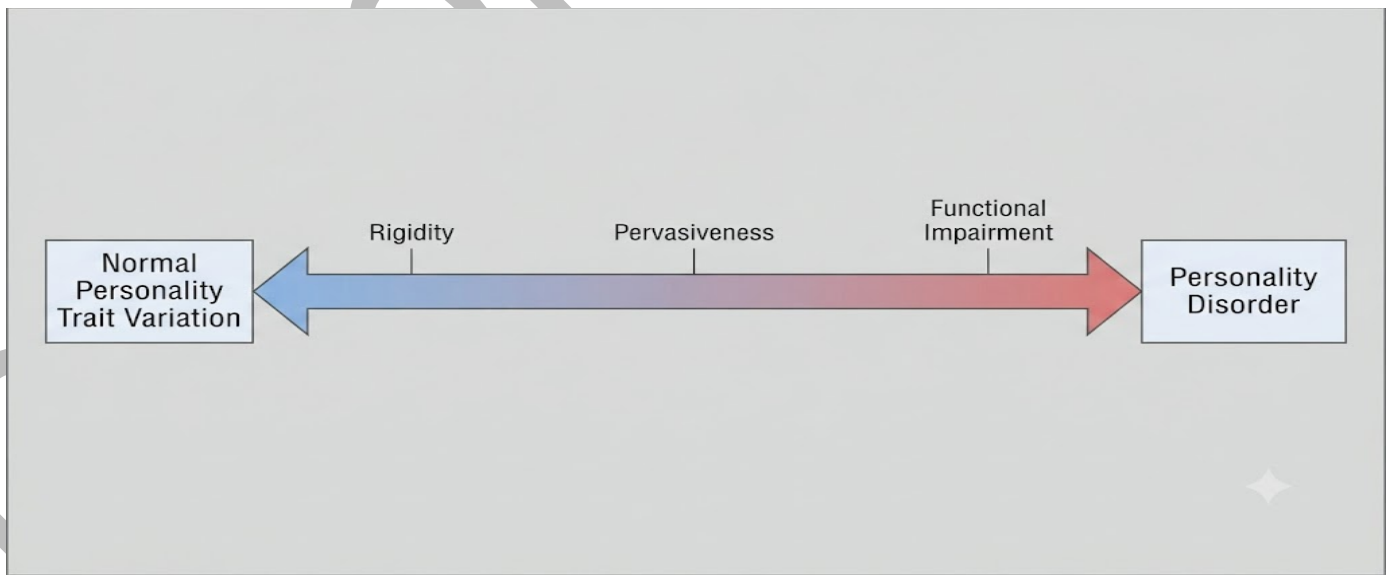


Figure 5.1: A diagram illustrating the spectrum from normal personality trait variation through to diagnosable personality disorder.

**Pilot questions 5.1**

- Distinguish personality traits from personality disorder. (Linked to SLO 5.1)
- Explain why personality disorder is best understood as a variant of normal personality rather than a separate phenomenon. (Linked to SLO 5.1)
- Explain the relevance of personality disorders to providing broader clinical care. (Linked to SLO 5.1)
- Define personality change due to another medical condition. (Linked to SLO 5.1)
- Explain why sudden personality change in adulthood should prompt consideration of a medical cause. (Linked to SLO 5.1)

## 5.2 Cluster A and Cluster B Personality Disorders

### 5.2.1 cluster a personality disorders

***The genuinely odd or eccentric cluster***

**Cluster A** personality disorders, discussed throughout this Part, share a genuine odd or eccentric quality, comprising **paranoid** personality disorder, pervasive distrust and suspiciousness of others, **schizoid** personality disorder, genuine detachment from social relationships and restricted emotional expression, and **schizotypal** personality disorder, genuine discomfort with close relationships together with eccentric behaviour and cognitive or perceptual distortion.

These three conditions, discussed earlier in this sub-Part, genuinely share some conceptual and, in schizotypal personality disorder particularly, genetic overlap with schizophrenia, discussed in an earlier Series of this course, without meeting full criteria for a primary psychotic disorder, meaning cluster A conditions occupy a genuinely important conceptual position adjacent to, though distinct from, the schizophrenia spectrum.

**Fill in the blank:** Cluster A personality disorders share a genuine odd or eccentric quality, comprising paranoid, schizoid, and schizotypal personality _____.

### 5.2.2 cluster b personality disorders: antisocial and borderline

***The genuinely dramatic, emotional, or erratic cluster, part one***

**Antisocial** personality disorder, discussed throughout this Part, describes a pervasive pattern of genuine disregard for and violation of the rights of others, generally emerging from a documented history of conduct disorder before the age of fifteen, while **borderline** personality

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disorder describes genuine instability of relationships, self-image, and emotion, together with marked impulsivity.

Both conditions, discussed earlier in this sub-Part, belong to **cluster B**, characterised overall by dramatic, emotional, or erratic presentation, with borderline personality disorder specifically carrying genuinely elevated risk of self-harm and suicide, discussed in relation to suicide risk in an earlier Series of this course, meaning careful, ongoing risk assessment remains genuinely essential in this specific patient population.

**Fill in the blank:** Borderline personality disorder describes genuine instability of relationships, self-image, and emotion, together with marked _____.

## 5.2.3 cluster b personality disorders: histrionic and narcissistic

***The genuinely dramatic, emotional, or erratic cluster, part two***

**Histrionic** personality disorder, discussed throughout this Part, describes pervasive, excessive emotionality and attention-seeking behaviour, while **narcissistic** personality disorder describes a genuine pervasive pattern of grandiosity, need for admiration, and lack of empathy, each completing the four recognised conditions within cluster B alongside antisocial and borderline personality disorder discussed earlier in this Part.

These four cluster B conditions, discussed earlier in this sub-Part, collectively represent the personality disorders most frequently encountered in general clinical practice, meaning genuine familiarity with their distinguishing features carries considerable practical value for essentially any clinician working across general medical or psychiatric settings.

**Fill in the blank:** Narcissistic personality disorder describes a genuine pervasive pattern of grandiosity, need for admiration, and lack of _____.

**Table 5.2: Comparing cluster A and cluster B personality disorders.**

| Disorder | Cluster | Core feature |
|---|---|---|
| Paranoid | A | Pervasive distrust and suspiciousness |
| Schizotypal | A | Discomfort with relationships and eccentric cognition |
| Borderline | B | Instability of relationships, self-image, and emotion |
| Narcissistic | B | Grandiosity, need for admiration, lack of empathy |

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**Pilot questions 5.2**

1. List the three cluster A personality disorders. (Linked to SLO 5.2)
2. Describe the shared quality characterising cluster A personality disorders. (Linked to SLO 5.2)
3. Define antisocial personality disorder. (Linked to SLO 5.2)
4. Define borderline personality disorder and its associated risk. (Linked to SLO 5.2)
5. Distinguish histrionic from narcissistic personality disorder. (Linked to SLO 5.2)

## 5.3 Cluster C Personality Disorders and Rational Prescribing

### 5.3.1 cluster c personality disorders

***The genuinely anxious or fearful cluster***

**Cluster C** personality disorders, discussed throughout this Part, share a genuine anxious or fearful quality, comprising **avoidant** personality disorder, genuine social inhibition and hypersensitivity to negative evaluation, **dependent** personality disorder, an excessive need to be cared for leading to submissive, clinging behaviour, and **obsessive-compulsive** personality disorder, a pervasive preoccupation with orderliness and control.

This final cluster, discussed earlier in this sub-Part, completes the genuine three-cluster conceptualisation of personality disorders, cluster A odd or eccentric, cluster B dramatic or erratic, and cluster C anxious or fearful, discussed throughout this Series, providing a genuinely comprehensive organisational framework for the full range of recognised personality disorders.

**Fill in the blank:** Cluster C personality disorders share a genuine anxious or fearful quality, comprising avoidant, dependent, and obsessive-compulsive personality _____.

### 5.3.2 principles of rational prescribing in psychiatry

***Genuinely evidence-based, individualised drug selection***

**Rational prescribing**, discussed throughout this Series, requires genuinely evidence-based drug selection matched to the specific patient's diagnosis, symptom profile, and individual circumstances, including coexisting medical conditions and concurrent medication, rather than a generic, one-size-fits-all approach to psychotropic treatment.

This principle, discussed earlier in this sub-Part, further requires genuinely ongoing monitoring of treatment response and side effects, discussed further later in this Series, and willingness to

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adjust or discontinue treatment where genuinely appropriate, meaning rational prescribing represents an ongoing, dynamic clinical process rather than a single, static initial prescribing decision.

**Fill in the blank:** Rational prescribing requires genuinely evidence-based drug selection matched to the specific patient's diagnosis, symptom profile, and individual _____.

## 5.3.3 adverse drug reactions in psychopharmacology

***Recognising and responding to genuine treatment-related harm***

**Adverse drug reactions**, discussed throughout this Part, range from genuinely mild, tolerable side effects to serious, potentially life-threatening reactions, meaning the prescriber must genuinely weigh anticipated therapeutic benefit against recognised adverse effect risk for every specific psychotropic agent considered, discussed further in relation to individual drug classes later in this Series.

Prompt recognition of adverse drug reactions, discussed earlier in this sub-Part, allows genuinely timely intervention, whether dose adjustment, discontinuation, or specific treatment of the reaction itself, meaning ongoing, vigilant monitoring for adverse effects represents an essential, continuing component of safe psychotropic prescribing practice.

**Fill in the blank:** Prompt recognition of adverse drug reactions allows genuinely timely intervention, whether dose adjustment, discontinuation, or specific treatment of the reaction _____.

**Table 5.3: The three-cluster conceptualisation of personality disorders.**

| Cluster | Shared quality | Included disorders |
|---|---|---|
| A | Odd or eccentric | Paranoid, schizoid, schizotypal |
| B | Dramatic or erratic | Antisocial, borderline, histrionic, narcissistic |
| C | Anxious or fearful | Avoidant, dependent, obsessive-compulsive |

**Pilot questions 5.3**

1. List the three cluster C personality disorders. (Linked to SLO 5.3)
2. Describe the shared quality characterising cluster C personality disorders. (Linked to SLO 5.3)

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3. Describe the three-cluster conceptualisation of personality disorders as a whole. (Linked to SLO 5.2, SLO 5.3)
4. Explain the principles of rational prescribing. (Linked to SLO 5.4)
5. Explain why ongoing monitoring for adverse drug reactions is essential. (Linked to SLO 5.4)

## 5.4 Major Psychotropic Drug Classes

### 5.4.1 antipsychotics and mood stabilisers

***Core treatments for psychotic and bipolar illness***

**Antipsychotics**, discussed in relation to schizophrenia management in an earlier Series of this course, act predominantly through dopamine receptor blockade, addressing positive psychotic symptoms, with recognised adverse effects including extrapyramidal symptoms and metabolic disturbance, meaning careful monitoring genuinely accompanies their use.

**Mood stabilisers**, discussed earlier in this sub-Part, including lithium and certain anticonvulsant agents, discussed further later in this Series, address the mood instability characteristic of bipolar disorder, discussed in an earlier Series of this course, each carrying a genuinely distinct mechanism, monitoring requirement, and adverse effect profile requiring specific, individual familiarity.

**Fill in the blank:** Antipsychotics act predominantly through dopamine receptor blockade, addressing positive psychotic symptoms, with recognised adverse effects including extrapyramidal symptoms and metabolic _____.

### 5.4.2 antidepressants and anxiolytics

***Core treatments for mood and anxiety disorders***

**Antidepressants**, discussed in relation to mood disorder treatment in an earlier Series of this course, generally act by modulating monoamine neurotransmitter systems, discussed in relation to neuroscience established in the opening Series of this course, with genuinely distinct classes, including selective serotonin reuptake inhibitors, carrying genuinely different specific adverse effect and pharmacokinetic profiles.

**Anxiolytics**, discussed earlier in this sub-Part, including benzodiazepines, discussed in relation to their withdrawal risk in the previous Series of this course, provide genuinely rapid

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symptomatic relief of anxiety, though carry recognised risk of dependence with prolonged use, meaning careful consideration of treatment duration represents an essential component of their rational, safe prescribing.

**Fill in the blank:** Antidepressants generally act by modulating monoamine neurotransmitter systems, with genuinely distinct classes carrying genuinely different specific adverse effect and pharmacokinetic _____.

## 5.4.3 anticonvulsants, cognitive enhancers, and drugs for dementia

***A further genuinely diverse range of psychotropic agents***

**Anticonvulsant** agents, discussed in relation to their mood stabilising role earlier in this Part, serve a further recognised role beyond seizure control, discussed further in relation to their specific psychiatric indications, while **cognitive enhancers** and **drugs for dementia**, including cholinesterase inhibitors, address cognitive decline through genuinely distinct mechanisms targeting specific neurotransmitter systems implicated in these conditions.

This diverse further range of agents, discussed earlier in this sub-Part, reflects the genuinely broad scope of clinical psychopharmacology beyond the more familiar antipsychotic and antidepressant classes discussed earlier in this Series, meaning comprehensive psychopharmacological competence genuinely requires familiarity across this full, diverse range of agents.

**Fill in the blank:** Cognitive enhancers and drugs for dementia, including cholinesterase inhibitors, address cognitive decline through genuinely distinct mechanisms targeting specific neurotransmitter _____.

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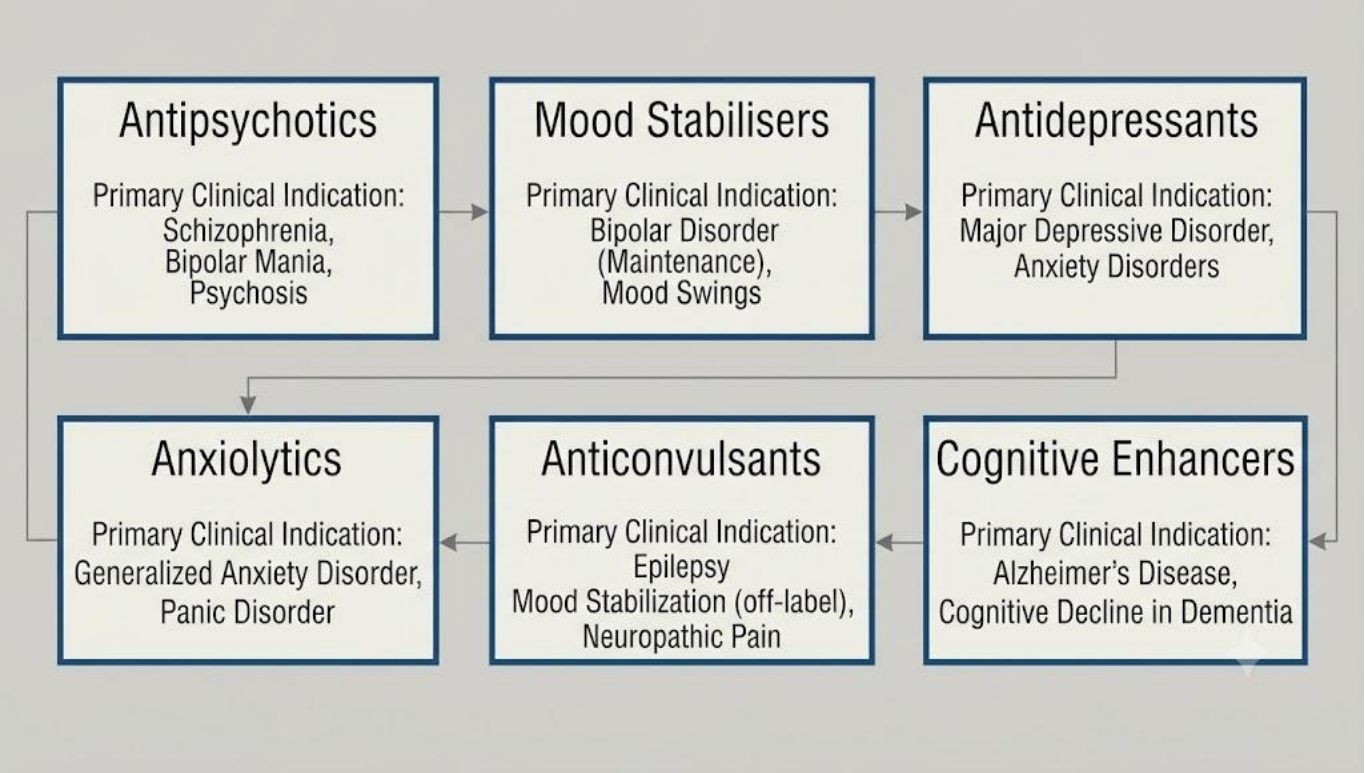

Figure 5.4: A diagram illustrating major psychotropic drug classes mapped to their primary clinical indication.

**Pilot questions 5.4**

1. Describe the mechanism of action and adverse effects of antipsychotics. (Linked to SLO 5.5)
2. Describe mood stabilisers and their clinical use. (Linked to SLO 5.5)
3. Describe the mechanism of action of antidepressants. (Linked to SLO 5.6)
4. Describe the risk associated with prolonged anxiolytic use. (Linked to SLO 5.6)
5. Describe the role of cognitive enhancers and drugs for dementia. (Linked to SLO 5.7)

## 5.5 Implementing and Monitoring Psychotropic Pharmacotherapy

### 5.5.1 stimulants, hypnotics, and drugs used in substance dependence

***Further specific agents addressing distinct clinical needs***

**Stimulants**, discussed throughout this Part, address disorders of attention and hyperactivity through genuinely targeted catecholaminergic mechanisms, while **hypnotic** agents address

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insomnia, each carrying recognised risk of misuse requiring careful, considered prescribing practice.

**Drugs used in substance dependence**, discussed in relation to substance use disorders in the previous Series of this course, including agents supporting withdrawal management or reducing cravings, represent a further genuinely important psychopharmacological category, meaning comprehensive psychiatric pharmacotherapy extends well beyond treatment of primary mood, anxiety, or psychotic disorders alone.

**Fill in the blank:** Stimulants address disorders of attention and hyperactivity through genuinely targeted catecholaminergic mechanisms, carrying recognised risk of _____ requiring careful, considered prescribing practice.

## 5.5.2 prescribing in pregnancy

***A genuinely careful risk-benefit balance for two patients at once***

**Prescribing in pregnancy**, discussed throughout this Part, requires genuinely careful weighing of the risk of untreated maternal psychiatric illness, itself carrying genuine risk to both mother and fetus, against the specific, recognised risk profile of individual psychotropic agents, discussed in relation to drug ionisation and placental transfer in related anaesthesiology coursework.

This genuinely careful risk-benefit balance, discussed earlier in this sub-Part, means decisions regarding psychotropic treatment during pregnancy should genuinely be individualised and, wherever possible, made collaboratively with the patient, reflecting the recognition that both undertreatment and inappropriate treatment carry genuine, meaningful risk.

**Fill in the blank:** Prescribing in pregnancy requires genuinely careful weighing of the risk of untreated maternal psychiatric illness against the specific, recognised risk profile of individual psychotropic _____.

## 5.5.3 implementing, monitoring, and discontinuing psychotropic pharmacotherapy

***The complete, ongoing arc of responsible pharmacological care***

**Implementing** psychotropic pharmacotherapy, discussed throughout this Series, requires genuine patient education regarding expected benefit, timeline to effect, and potential side effects, while **monitoring**, discussed earlier in this Series, requires structured, regular follow-up assessing both therapeutic response and adverse effects throughout the entire treatment course.

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**Discontinuing** treatment, discussed earlier in this sub-Part, generally requires genuinely gradual tapering for many psychotropic agents to avoid discontinuation symptoms, together with careful clinical judgement regarding the appropriate timing and circumstances for stopping treatment, meaning the complete arc of psychotropic pharmacotherapy, from implementation through monitoring to eventual discontinuation, demands genuinely sustained, ongoing clinical attention.

**Fill in the blank:** Discontinuing psychotropic treatment generally requires genuinely gradual tapering for many agents to avoid discontinuation _____.

**Table 5.5: The complete arc of psychotropic pharmacotherapy.**

| Stage | Key activity | Purpose |
|---|---|---|
| Implementing | Patient education on benefit, timeline, and side effects | Supports informed, engaged treatment initiation |
| Monitoring | Structured, regular follow-up assessment | Confirms response and detects adverse effects |
| Discontinuing | Gradual, individualised tapering | Minimises discontinuation symptoms |

**Pilot questions 5.5**

1. Describe the clinical use and risk associated with stimulants and hypnotics. (Linked to SLO 5.8)
2. Describe drugs used in substance dependence. (Linked to SLO 5.8)
3. Explain the risk-benefit balance relevant to prescribing in pregnancy. (Linked to SLO 5.9)
4. Describe the components of implementing psychotropic pharmacotherapy. (Linked to SLO 5.10)
5. Explain why gradual tapering is generally required when discontinuing psychotropic treatment. (Linked to SLO 5.10)

## Series Summary

This final Series set out to build a thorough, practical understanding of personality disorders and the everyday realities of clinical psychopharmacology, and each Part has now added its own piece to that picture. Part 5.1 established how personality traits shade into genuine personality disorder, and why this matters for the therapeutic relationship itself, while Parts 5.2 and 5.3

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worked through the full three-cluster conceptualisation in turn, cluster A's odd or eccentric presentations, cluster B's dramatic or erratic patterns, and cluster C's anxious or fearful traits, before Part 5.3 turned to the principles of rational, evidence-based prescribing and the adverse reactions every prescriber must watch for. Part 5.4 then surveyed the major psychotropic drug classes in turn, antipsychotics, mood stabilisers, antidepressants, anxiolytics, anticonvulsants, and cognitive enhancers, and Part 5.5 closed the Series with stimulants, hypnotics, and dependence treatments, the genuinely careful balance prescribing in pregnancy demands, and the complete arc of implementing, monitoring, and safely discontinuing psychotropic treatment.

Taken together, you should now be genuinely able to discuss the relevance of personality disorders in providing care, describe the three-cluster conceptualisation with its typical features, discuss the major psychotropic drug classes with regard to their indications and adverse effects, and enumerate the factors relevant to implementing, monitoring, and discontinuing pharmacotherapy, directly fulfilling every Series Learning Outcome set out at the start of this Series. Across this entire course, you have now worked through the history, aetiology, ethics, and neuroscience of psychiatric disorders, classification, psychopathology, and assessment, mood and schizophrenia spectrum disorders, anxiety, OCD, trauma, and substance use disorders, and, finally, personality disorders and clinical psychopharmacology, together forming a genuinely comprehensive foundation in general psychiatry addressed throughout PSY 601.

**Glossary of Terms**

6. **Adverse drug reaction:** an unintended, potentially harmful effect resulting from a medication.
7. **Antisocial personality disorder:** a pervasive pattern of disregard for and violation of the rights of others.
8. **Avoidant personality disorder:** genuine social inhibition and hypersensitivity to negative evaluation.
9. **Borderline personality disorder:** genuine instability of relationships, self-image, and emotion, with marked impulsivity.
10. **Cluster A personality disorders:** personality disorders sharing an odd or eccentric quality: paranoid, schizoid, and schizotypal.
11. **Cluster B personality disorders:** personality disorders sharing a dramatic or erratic quality: antisocial, borderline, histrionic, and narcissistic.
12. **Cluster C personality disorders:** personality disorders sharing an anxious or fearful quality: avoidant, dependent, and obsessive-compulsive.
13. **Cognitive enhancer:** a medication addressing cognitive decline, such as a cholinesterase inhibitor.
14. **Mood stabiliser:** a medication addressing mood instability, such as in bipolar disorder.

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15. **Narcissistic personality disorder:** a pervasive pattern of grandiosity, need for admiration, and lack of empathy.
16. **Personality change due to another medical condition:** a persistent personality alteration directly attributable to an identifiable medical condition.
17. **Personality disorder:** an inflexible, pervasive, functionally impairing pattern of personality traits.
18. **Rational prescribing:** evidence-based drug selection matched to a patient's specific diagnosis and circumstances.
19. **Schizotypal personality disorder:** discomfort with close relationships together with eccentric behaviour and cognitive distortion.

## Concept Check Questions [Series 5]

### Objective questions

- A personality disorder occurs when personality traits are genuinely inflexible, pervasive across essentially every life context, and cause significant distress or functional _____.
- Cluster A personality disorders share a genuine odd or eccentric quality, comprising paranoid, schizoid, and schizotypal personality _____.
- Rational prescribing requires genuinely evidence-based drug selection matched to the specific patient's diagnosis, symptom profile, and individual _____.
- Antipsychotics act predominantly through dopamine receptor blockade, addressing positive psychotic symptoms, with recognised adverse effects including extrapyramidal symptoms and metabolic _____.
- Discontinuing psychotropic treatment generally requires genuinely gradual tapering for many agents to avoid discontinuation _____.

### Short-answer questions

1. Distinguish personality traits from personality disorder.
2. List the three cluster B personality disorders discussed involving instability and grandiosity.
3. List the three cluster C personality disorders.
4. Describe the mechanism of action of antidepressants.
5. Describe the risk-benefit balance relevant to prescribing in pregnancy.

### Long-answer questions

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6. Discuss the concepts and relevance of personality traits and disorders in providing care. (Linked to SLO 5.1)
7. Discuss the three-cluster conceptualisation of personality disorders and typical features of each cluster. (Linked to SLO 5.2, SLO 5.3)
8. Discuss the principles of rational prescribing and adverse drug reactions. (Linked to SLO 5.4)
9. Discuss the major psychotropic drug classes with regard to indications, mechanism of action, and adverse effects. (Linked to SLO 5.5, SLO 5.6, SLO 5.7)
10. Discuss factors relevant to implementing, monitoring, and discontinuing psychotropic pharmacotherapy, including in pregnancy. (Linked to SLO 5.8, SLO 5.9, SLO 5.10)

**Answers to Concept Check Questions [Series 5]**

**Objective questions**

11. Impairment.
12. Disorders.
13. Circumstances.
14. Disturbance.
15. Symptoms.

**Short-answer questions**

16. Personality traits are normal, enduring patterns present in everyone; personality disorder involves genuinely inflexible, pervasive, impairing traits.
17. Antisocial, borderline, histrionic, and narcissistic personality disorder.
18. Avoidant, dependent, and obsessive-compulsive personality disorder.
19. They generally act by modulating monoamine neurotransmitter systems.
20. Weighing the risk of untreated maternal illness against the recognised risk profile of individual psychotropic agents, decided individually and collaboratively.

**Long-answer questions**

21. **Basic response:** Personality disorder represents an extreme, maladaptive variant of normal personality traits, causing genuine functional impairment.

**Value-added response:** It carries genuine relevance to care given its meaningful influence on the therapeutic relationship and management of coexisting conditions.

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22. **Basic response:** The three-cluster model organises personality disorders as odd/eccentric (A), dramatic/erratic (B), and anxious/fearful (C).

**Value-added response:** Each cluster comprises several specific, distinct disorders sharing that overall characteristic quality.

23. **Basic response:** Rational prescribing matches evidence-based drug selection to the individual patient's diagnosis and circumstances.

**Value-added response:** Ongoing vigilance for adverse drug reactions, and willingness to adjust treatment, represents an essential, continuing component of safe practice.

24. **Basic response:** Antipsychotics, mood stabilisers, antidepressants, anxiolytics, anticonvulsants, and cognitive enhancers each address specific, distinct clinical presentations.

**Value-added response:** Each class carries a genuinely distinct mechanism, adverse effect profile, and monitoring requirement demanding specific familiarity.

25. **Basic response:** Implementing, monitoring, and discontinuing pharmacotherapy each require distinct, careful clinical attention across the treatment course.

**Value-added response:** Prescribing in pregnancy exemplifies this careful, individualised balance, weighing untreated illness risk against specific drug risk.

**Answers to Pilot Questions [Series 5]**

**Part 5.1**

1. Personality traits are normal, enduring patterns present in everyone; personality disorder is a genuinely inflexible, pervasive, impairing variant.
2. Because it represents an extreme, maladaptive variant of normal personality variation rather than a categorically distinct phenomenon.
3. It meaningfully shapes how a patient engages with treatment and relates to the clinician, complicating management of coexisting conditions.
4. A genuine, persistent personality alteration directly attributable to the physiological effects of an identifiable medical condition.
5. Because it may indicate an underlying organic cause rather than a primary, developmental personality disorder.

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**Part 5.2**

6. Paranoid, schizoid, and schizotypal personality disorder.
7. A genuine odd or eccentric quality.
8. A pervasive pattern of disregard for and violation of the rights of others.
9. Genuine instability of relationships, self-image, and emotion, with marked impulsivity; carries elevated self-harm and suicide risk.
10. Histrionic involves excessive emotionality and attention-seeking; narcissistic involves grandiosity, need for admiration, and lack of empathy.

**Part 5.3**

11. Avoidant, dependent, and obsessive-compulsive personality disorder.
12. A genuine anxious or fearful quality.
13. Cluster A (odd/eccentric), cluster B (dramatic/erratic), and cluster C (anxious/fearful).
14. Evidence-based drug selection matched to the patient's diagnosis, symptom profile, and individual circumstances, with ongoing monitoring.
15. Because it allows timely intervention, whether dose adjustment, discontinuation, or specific treatment of the reaction itself.

**Part 5.4**

1. They act predominantly through dopamine receptor blockade; adverse effects include extrapyramidal symptoms and metabolic disturbance.
2. Mood stabilisers, including lithium and certain anticonvulsants, address mood instability in bipolar disorder.
3. They generally act by modulating monoamine neurotransmitter systems.
4. Prolonged use carries recognised risk of dependence.
5. They address cognitive decline through mechanisms targeting specific neurotransmitter systems, such as cholinesterase inhibition.

**Part 5.5**

1. Stimulants address attention and hyperactivity disorders; hypnotics address insomnia; both carry recognised misuse risk.
2. Agents supporting withdrawal management or reducing cravings in patients with substance dependence.
3. Weighing the risk of untreated maternal illness against the recognised risk profile of individual psychotropic agents.
4. Patient education regarding expected benefit, timeline to effect, and potential side effects.

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5. To avoid discontinuation symptoms that can occur with abrupt cessation of many psychotropic agents.

**References and Attributions [Series 5]**


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7. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).
8. Stahl, S. M. (2021). Stahl's Essential Psychopharmacology (5th ed.). Cambridge University Press.
9. Taylor, D., Barnes, T. R. E., & Young, A. H. (2021). The Maudsley Prescribing Guidelines in Psychiatry (14th ed.). Wiley-Blackwell.


**Figures, Plates, Tables, and Boxes**

1. Figure 5.1: A diagram illustrating the spectrum from normal personality trait variation through to diagnosable personality disorder. AI-generated using the prompt: "A single clean, accurate schematic horizontal spectrum diagram with one end labelled Normal Personality Trait Variation and the other labelled Personality Disorder, with small annotation labels reading Rigidity, Pervasiveness, and Functional Impairment positioned along the spectrum, textbook psychiatry diagram style, neutral background, no photographic realism, no other panels."
2. Table 5.2: Comparing cluster A and cluster B personality disorders. AI-generated using the prompt: "Create a clean clinical reference table titled Comparing Cluster A and Cluster B Personality Disorders, listing disorder, cluster, and core feature. Medical reference table style with outside border, no photographic elements."
3. Table 5.3: The three-cluster conceptualisation of personality disorders. AI-generated using the prompt: "Create a clean clinical reference table titled The Three-Cluster Conceptualisation of Personality Disorders, listing cluster, shared quality, and included disorders. Medical reference table style with outside border, no photographic elements."
4. Figure 5.4: A diagram illustrating major psychotropic drug classes mapped to their primary clinical indication. AI-generated using the prompt: "A single clean, accurate schematic diagram with six labelled boxes representing Antipsychotics, Mood Stabilisers, Antidepressants, Anxiolytics, Anticonvulsants, and Cognitive Enhancers, each with a small annotation indicating its primary clinical indication, textbook pharmacology diagram style, neutral background, no photographic realism, no other panels."

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5. Table 5.5: The complete arc of psychotropic pharmacotherapy. AI-generated using the prompt: "Create a clean clinical reference table titled The Complete Arc of Psychotropic Pharmacotherapy, listing stage, key activity, and purpose. Medical reference table style with outside border, no photographic elements."

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